DATA LABEL: Public

West Lothian Council

Health and Care Policy Development and Scrutiny Panel

West Lothian Civic Centre
Howden South Road
LIVINGSTON
EH54 6FF

17 August 2017

A meeting of the **Health and Care Policy Development and Scrutiny Panel** of West Lothian Council will be held within the **Council Chambers, West Lothian Civic Centre** on **Thursday 24 August 2017** at **2:00pm**.

For Chief Executive

BUSINESS

Public Session

1. Apologies for Absence

2. Declarations of Interest - Members should declare any financial and non-financial interests they have in the items of business for consideration at the meeting, identifying the relevant agenda item and the nature of their interest.

3. Order of Business, including notice of urgent business and declarations of interest in any urgent business

4. Confirm Draft Minutes of Meeting of Health and Care Policy Development and Scrutiny Panel held on Thursday 01 June 2017 (herewith).

5. NHS Lothian Health Board Minute - Report by Depute Chief Executive (herewith)

6. West Lothian IJB Minute - Report by Depute Chief Executive (herewith)

7. Together for Health Update - Report by Head of Planning, Economic Development and Regeneration (herewith)

DATA LABEL: Public

8. Health Improvement Priorities - Report by Consultant in Public Health (herewith)

9. European Foundation for Quality Management (EFQM) Levels of Excellence Programme - Report by Depute Chief Executive (herewith)

10. Audit Scotland Report - Social Work in Scotland - Report by Head of Social Policy (herewith)

11. Workplan (herewith)

NOTE **For further information please contact Val Johnston, Tel No.01506 281604 or email val.johnston@westlothian.gov.uk**

MINUTE of MEETING of the HEALTH AND CARE POLICY DEVELOPMENT AND SCRUTINY PANEL of WEST LOTHIAN COUNCIL held within COUNCIL CHAMBERS, WEST LOTHIAN CIVIC CENTRE, on 1 JUNE 2017.

Present – Councillors John McGinty (Chair), George Paul, Janet Campbell, David Dodds, Charles Kennedy and Damian Timson

Absent – Councillor Dom McGuire

1. DECLARATIONS OF INTEREST

No declarations of interest were made.

2. MINUTE

The Panel confirmed the Minute of its meeting held on 6 April 2017. The Minute was thereafter signed by the Chair.

3. NHS LOTHIAN HEALTH BOARD MINUTE

A report had been circulated by the Depute Chief Executive to which was attached the Minute of the NHS Lothian Health Board meeting held on 1 February 2017.

Decision

To note the contents of the report

4. WEST LOTHIAN INTEGRATION JOINT BOARD MINUTE

A report had been circulated by the Depute Chief Executive to which was attached the Minute of the West Lothian Integration Joint Board (IJB) meeting held on 14 March 2017

Decision

To note the contents of the report

5. WEST LOTHIAN PALLIATIVE CARE SERVICE

The Panel considered a report (copies of which had been circulated) by the Clinical Director, West Lothian Health and Care Partnership providing an update on further partnership development in the West Lothian Palliative Care Service.

The West Lothian Palliative Care Service was re-launched in April 2014. The activity within the service had exceeded initial projections and indications were that this would continue to increase. The value of the service had also been recognised formally by achieving a national award,

The Herald Society Award in November 2016, and was highly thought of by local partners.

The success of the service lay in it partnerships with local primary care and acute colleagues in health and social care. Recognising the highly specialised nature of this important service, Social Policy had invested in a dedicated social work resource, working closely with the team to ensure that services were streamlined.

In addition to the more traditional assessment and care management role, the specialist social worker would work with individuals and families pre-bereavement and would work with the team to recruit and support volunteers to develop local bereavement support group work.

Although a very successful and valued service in West Lothian it had been recognised that further integration and additional investment would support the service to grow from the established strong foundation to further consolidate and improve.

A business case was therefore submitted to Marie Cure in November 2016 seeking additional resources to deliver the aspirations of the team. This had resulted in an additional 0.5fte social work post to support the team in the delivery of its service.

The Panel was asked to note the development of a more integrated approach to the delivery of palliative care services in West Lothian.

Decision

1) To note the contents of the report;

2) To note that excellent partnership working across West Lothian was helping deliver palliative care services; and

3) To request that the Head of Social Policy circulate to all Panel Members the total number of staff that constituted the Palliative Care Service in West Lothian.

6. WEST LOTHIAN PRIMARY CARE SUMMIT

The Panel considered a report (copies of which had been circulated) by the Clinical Director, Health and Care Partnership advising of the outcome of the West Lothian Primary Care Summit held on 22 February 2017 and planned developments moving forward.

The Panel were advised that following the pan-Lothian Primary Care Summit on 29 September 2016 outlining the crisis in Primary Care, NHS Lothian pledged an additional £2m recurrent funding for 2017-18 to support general practice. Each partnership area then held a local summit to consider how this additional funding could be used to support GP practices, reduce workload and increase practice stability and sustainability.

The West Lothian Primary Care Summit took place on 22 February 2017 and involved around 75 participants from numerous stakeholder groups including Health and Social Care Partnership members, GP's, practice managers, representatives from secondary care, Scottish Ambulance Service, Social Care, Pharmacy and the third sector. Participants worked in groups to identify strengths and assets in the health and social care sector in West Lothian and how these could be used to reduce GP workload, support service provision and develop a sustainable service for the future.

The key findings from the summit were as follows :-

- Invest in IT
- Further develop Signposting
- Expand the Primary Care Team
- Develop support hubs
- Support Advanced Nurse Practitioner training
- Continue to support and expand REACT hospital at home
- Advance health and social care integration

The Clinical Director then provided the Panel with an update on a number of the themes and how they were being developed. This included :-

- ❖ Continued expansion of the use of technology for example portable devices for GP's so they could access patient records whilst on the go; and text reminders to patients for GP appointments with the option to cancel;
- ❖ Continue "signposting" patients away from GP's to other services such as pharmacies and opticians. This has included working with the council to raise awareness in the community of the "signposting" campaign including the display of posters in council facilities such as libraries. This initiative has also included training being provided to key GP frontline staff to enable them to "signpost" patients away from GP appointments to more appropriate services; and
- ❖ Inclusion in the Primary Care Team of other medical professions including Ambulance Paramedics, currently being trialled in the Deans area and the inclusion of Mental Health Nurses.

The Clinical Director and the Head of Social Policy concluded their presentation by advising the Panel that the key themes would be incorporated into the West Lothian Primary Care Development Plan and would be presented to the Primary Care Investment and Redesign Board.

The Panel was asked to note the contents of the report and support the

efforts of the Health and Care Partnership to maintain GP service provision for West Lothian patients.

The Chair thanked the staff for the very informative presentation.

Decision

1. To note the contents of the report;

2. To note the themes that had emerged from the West Lothian Primary Care Summit;

3. To note the update on progress with some of those key themes; and

4. To request that a copy of the "Signposting" poster be circulated to all members of the Panel.

7. COMMUNITY CHOICES AND LET'S GET IT RIGHT FOR AUTISM

The Panel considered a report (copies of which had been circulated) by the Head of Social Policy providing an update on the Participatory Budget (PB) and the Let's Get it Right for Autism in West Lothian project.

Participatory Budgeting (PB) or "Community Choices" as it was being called in Scotland was a democratic process in which members of the community helped decide how to spend part of a public budget. West Lothian Council had secured support from the Scottish Government to take forward community choices with assistance from the organisation Participatory Budget Process.

Following on from the initial work, a development project "Let's Get it Right for Autism" was created with £10,000 from the Autism Strategy allocated to this project. This would them provide the opportunity for parents and carers of individuals with autism to decide how the funding was spent to improve the lives of those with autism.

The project was being linked to the outcomes in West Lothian's Autism Strategy which had been used to help set the priorities for the project. To ensure that the scope of the project was appropriate to meet the needs of those with autism a survey was carried out in December 2016. 342 people responded to the survey. Therefore based on the results of the survey the focus of the "Let's Get it Right for Autism" project aimed to support and encourage greater participation in social activities and opportunities for individuals with autism.

Local groups, organisations and clubs were asked to bid for funding (maximum of £2,000) to take forward their ideas on how they could support and encourage greater participation in social activities and opportunities for those living with autism.

A Community Launch event was held on 25 March 2017 where ideas from the local group, clubs and organisations were presented. The event was

open to the wider community who had an opportunity to vote for the ideas they thought would make a difference to individuals with autism. The date for the event was chosen to coincide with National Autism Awareness Week.

A range of people attended the event which resulted in 29 people engaging in the voting process. Online voting was also made available to those who were unable to attend the event. A great response was received to the online voting system; 792 individuals voted which therefore totalled 821 votes.

The successful projects were then announced at a short presentation on 26 April 2017 at West Lothian Civic Centre. These were as follows :-

- Broxburn United Sports Club and Team United with "Talking Tactics"
- Signpost and their "Lego Club"
- Winchburgh Youth Space with "Winchburgh Inspiring Inclusion"
- Youth Inclusion Project
- Barnado's and their "Caern Project"

The Head of Social Policy concluded that the successful projects would be monitored and evaluated and the outcome and lessons learned from the development project would be taken into consideration by the Community Planning Partnership for future Community Choice projects going forward.

The Panel were asked to note the work being undertaken as part of the community choices project.

Decision

To note the content of the report

8. WORKPLAN (HEREWITH)

The Panel noted the contents of the workplan which form the basis of the panel's work over the coming months.

Decision

To note the contents of the workplan

West Lothian Council

HEALTH AND CARE POLICY DEVELOPMENT AND SCRUTINY PANEL

NHS LOTHIAN BOARD

REPORT BY DEPUTE CHIEF EXECUTIVE

A. PURPOSE OF REPORT

To update members on the business and activities of Lothian NHS Board.

B. RECOMMENDATION

To note the terms of the minutes of Lothian NHS Board dated 5th April 2017 in the Appendix to this report.

C. SUMMARY OF IMPLICATIONS

I	**Council Values**	Focusing on our customers' needs Being honest, open and accountable Working in partnership.
II	**Policy and Legal (including Strategic Environmental Assessment, Equality Issues, Health or Risk Assessment)**	Council requires the activities of certain outside bodies to be reported to elected members on a regular basis, as part of its Code of Corporate Governance.
III	**Implications for Scheme of Delegations to Officers**	None.
IV	**Impact on performance and performance Indicators**	Working in partnership.
V	**Relevance to Single Outcome Agreement**	We live longer, healthier lives.
VI	**Resources - (Financial, Staffing and Property)**	None.
VII	**Consideration at PDSP**	Regularly reported to Health & Care PDSP for noting.
VIII	**Other consultations**	None required.

D. TERMS OF REPORT

On 29 June 2010 the Council Executive decided that the activities of certain outside bodies should be reported within the council to ensure all elected members are aware of the business of those bodies and to help to ensure their activities are more effectively scrutinised.

In accordance with that decision the business of Lothian NHS Board was to be reported to this meeting by the production of its minutes. The relevant documents are produced in the Appendix to this report.

E. CONCLUSION

This report ensures that members are kept appraised of the activities of Lothian NHS Board as part of the council's Code of Corporate Governance.

F. BACKGROUND REFERENCES

West Lothian Council Code of Corporate Governance.

Council Executive, 29 June 2010

Appendices/Attachments: 1

Appendix 1 Minutes of the meeting of NHS Lothian Board held on 5th April 2017

Contact Person: Jim Forrest, Depute Chief Executive
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CMT Member: Jim Forrest, Depute Chief Executive

Date: 24th August 2017

LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday 5 April 2017 in the Scottish Health Service Centre, Crewe Road South, Edinburgh, EH4 2LF.

Present:

Non-Executive Board Members: Mr B Houston (Chair); Mrs S Allan (Vice Chair); Mr M Ash; Councillor D Grant; Councillor R Henderson; Mr M Hill (from 10am); Ms C Hirst; Ms F Ireland; Mr A Joyce; Mrs J McDowell; Mrs A Mitchell; Mr P Murray; Mr J Oates and Professor M Whyte.

Executive and Corporate Directors: Mr J Crombie (Deputy Chief Executive); Mr T Davison (Chief Executive); Miss T Gillies (Medical Director); Mrs S Goldsmith (Director of Finance); Professor A K McCallum (Director of Public Health & Health Policy); Professor A McMahon (Executive Director, Nursing, Midwifery & AHPS – Executive Lead REAS & Prison Healthcare) and Dr S Watson (Chief Quality Officer).

In Attendance: Mrs R Kelly (Associate Director of Human Resources – representing Mrs J Butler) and Mr D Weir (Corporate Services Manager).

Apologies for absence were received from Mrs K Blair, Mrs J Butler, Councillor H Cartmill, Mr P Johnston, Councillor C Johnstone, Mrs L Williams and Dr R Williams.

Welcome and Introduction

The Chairman thanked colleagues for their good wishes during the early stages of his recent illness.

The Chairman welcomed members of the public and press to the Board meeting

Declaration of Financial and Non-Financial Interest

The Chairman reminded members they should declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. There were no declarations of interest.

Valedictory Comments

The Chairman commented that this would be the last Public Board meeting for Councillor Grant, Mr Johnston and Mrs McDowell and that a suitable leaving event would be organised. It was noted that attempts had been made to organise an informal lunch but the eventual numbers had made this unviable. The Chairman on behalf of the Board recorded his appreciation for the contributions made by members and wished them good fortune in the future.

1. Items for Approval

1.1 The Chairman reminded members that the agenda for the current meeting had been circulated previously to allow Board members to scrutinise the papers and advise whether any items should move from the approval to the discussion section of the agenda. There had been no such notifications.

1.2 The Chairman sought and received the approval of the Board to accept and agree the following recommendations contained in the previously circulated "For Approval" paper without further discussion:-

1.3 Minutes of the previous Board meeting held on 1 February 2017 - Approved.

1.4 Running Action Note – Approved.

1.5 Corporate Risk Register – The Board accepted the paper as assurance that the corporate risk register contained all appropriate risks which were contained in section 3.2 and set out in detail in appendix 1, and to inform assurance requirements. The Board also acknowledged that as a system of control, the Governance Committees of the Board had been asked to assess the level of assurance provided with respect to plans in place to mitigate the risks pertinent to the committee.

1.6 Finance and Resources – Minutes of 18 January 2017 – Endorsed.

1.7 Healthcare Governance Committee – Minutes of 17 January 2017 – Endorsed.

1.8 Acute Hospitals Committee – Minutes of 6 December 2016 and 22 February 2017 – Endorsed.

1.9 Staff Governance Committee – Minutes of 26 October 2016 and 25 January 2017 – Endorsed.

1.10 Strategic Planning Committee – Minutes of 8 December 2016 and 9 February 2017 – Endorsed.

1.11 Audit and Risk Committee – Minutes of 5 December 2016 and 27 February 2017 – Endorsed.

1.12 West Lothian Integration Joint Board – Minutes of 31 January 2017 - Endorsed.

1.13 East Lothian Integration Joint Board – Minutes of 21 December 2016 and 26 January 2017 - Endorsed.

1.14 Edinburgh Integration Joint Board – Minutes of 20 January and 17 February 2017 - Endorsed.

1.15 Midlothian Integration Joint Board – Minutes of 1 December 2016 - Endorsed.

Items for Discussion

2. Scottish Government Health and Social Care Delivery Plan and the Development of an East of Scotland Regional Health and Social Care Delivery Plan

2.1 The Chairman commented that he anticipated that this item along with the next item on the '2017/18 draft Local Delivery Plan including the 2017/18 financial plan' would represent the main items of discussion at the current meeting. He commented that an additional dimension over previous years was the introduction of a regional delivery plan.

2.2 It had been felt to be important that Board members had sight of the Scottish Government Health and Social Care Delivery Plan and the East of Scotland Regional Health and Social Care Delivery Plan with it being noted that the standards and timelines of these were reflected in the Local Delivery Plan (LDP) and corporate objectives both of which would be discussed later on the agenda. The key challenges were around the reduction of beds, the development of a primary care structure, outpatients and treatment centres.

2.3 The Board noted that the Scottish Government had asked that regional plans be submitted by September 2017. The Chief Executive of NHS Lothian had been appointed to lead the delivery of the regional Health and Social Care Development Plan for the East Region. It was reported that the Chief Executive as the Chair of the South East and Tayside Regional Planning Group had established a discussion forum to bring key stakeholders together to discuss issues within the context of improvement plans, finance, workforce and regional planning for the acute services. A Programme Board would meet at the end of December with progress being reported to future Board meetings. The Board received details of the other Boards involved within the East Regional Planning process with it being noted that communications on an ongoing basis would be important. It was anticipated that the Health and Social Care Delivery Plans would be developed and delivered through the transformation process.

2.4 The Board noted that anticipated changes to Health Board structures had not occurred although the Scottish Government had recognised the advantages of regional working for planning purposes as well as for the management of resources. It was noted that under the East of Scotland arrangements that 9 Boards of governance were involved in the regional planning process and that all of these organisations would be developing financial plans and commissioning services. It was noted that this represented a sophisticated landscape and that governance arrangements would develop on an iterative basis. The Board noted that the East Region represented around 25% of Scotland and in that regard there were significant planning aspects to be addressed. The Board noted that a regional financial plan was also being developed with the key issue being around how to develop financial sustainability.

2.5 The point was made that the Board paper stated that at this point it was not known how performance would be monitored. The question was raised about whether NHS Lothian would have an opportunity to set its own standards with it also being questioned what steps would be taken to influence the process moving forward. The

Board were advised that the National Delivery Plan set clear expectations and was clear about how priorities and timescales would be evaluated. It was pointed out however that through the 6 Integration Joint Boards (IJBs) of governance that there were real opportunities to enhance local as well as regional services. A National Programme Board had been established to drive a national plan and the 3 Lead Regional Chief Executives would serve as part of the National Board and would have a part to play in shaping the agenda and how this would be approached in each region.

2.6 The Board noted that the Chief Executive had met with the Chief Executive's and Chief Officers of the 6 IJBs to discuss the regional planning process and that whilst there was no real flexibility around the national direction there was flexibility around how achievement could be delivered.

2.7 A question was raised in respect of the expectation that IJBs would deliver a 10% reduction in unscheduled care bed days in Lothian with clarification being sought around whether this meant a reduction in bed days or a reduction in bed numbers. The Board were advised that the direction was around reducing bed numbers although it would be important that that a sensible approach was adopted.

2.8 The Board were reminded at the recent Board Development Session it has been reported that unscheduled care acute beds were running at 95% capacity and that this led to inappropriate boarding and further delays. It was noted that an 85% occupancy rate was the aspiration and if 60,000 bed days could be reduced this would move the system to the 85% level. This would allow the system to operate safer with a more sustainable acute sector providing better quality and safety of care for patients with it being stressed however that this would not release costs. The point was made that if cost was to be taken out of the system then beds would need to be reduced, which might lead to an increase in occupancy rates.

2.9 The Board were referred to a recent Nuffield report on 'Shifting the Balance of Care: Great Expectations' which suggested that whilst alternatives to hospital care improved the quality of care and patient experience that it did not result in a reduction in cost. The Chief Executive commented that he still felt that it was the correct course of action to drive the Shifting the Balance of Care policy although concurrently there was also a need to drive efficiency savings out of the system.

2.10 The Board were advised that elements of the national plan would be consulted upon nationally with discussions also having been held about regional aspects. The focus moving forward would be to deliver the national plan on a regional basis with the Scottish Government looking for specific priorities to be in place to cover a 2 – 3 year timeframe leading up to a 10 – 15 year approach although this represented challenges in respect of Macro / micromanagement. The longer term view would be that national planning would drive creativity to deliver large set piece infrastructure solutions and that consultation would need to reflect engagement requirements.

2.11 The point was made by a Board member that at the Cabinet Secretary launch the expectation had been that there would be a movement of resources as a result of reduced bed days although the point was made that this did not necessarily represent a one to one relationship.

2.12 The Chief Executive commented that he was clear about the need for bed closures which were required to release resource. Reference was made to the impending closure of Liberton Hospital, community care beds and longer term beds at the Royal Edinburgh Hospital which were already closing.

2.13 The Board noted the recommendations contained in the circulated paper.

3. 2017/18 Draft Local Delivery Plan Including 2017/18 Financial Plan

3.1 The Chairman drew the recommendations contained in the circulated paper to the attention of the Board.

3.2 The Board were advised that the Director of Finance was conscious that only a one year plan was being presented and that this was problematic in terms of future planning. One aspect was the conversation around the relationship between IJB beds and the configuration of services which was absent from the financial plan with there being a need to consider the development of a longer term financial plan. It had not been possible at this juncture to bring forward a 3 year plan to the Board as this would not have been balanced. An iterative process was currently underway to attempt to reach a balanced position. The current year financial plan did not reflect Directions from IJBs although the specificity of this would emerge with there being a need for reflection in future financial plans. The Board were advised that within finance there was a need to get away from the focus on balancing the books each year and the need to move to the development of longer term financial strategies.

3.3 The Board were advised that when the financial plan had been presented in February 2017 that it had reported a potential £51m deficit and this position had been improved. It was reported that Directors of Finance were working together to identify further non-recurring sources of funding. In addition to this a more Regional approach to financial planning was underway locally with business units and individual Executive Directors were examining every option to reduce the cost base.

3.4 A Development Session has been held on the 1 March to respond to the Boards earlier concerns around the prescribing position and an additional allocation of £3m had been made to reflect this and bring spend up to the 2016/17 position. This would be reflected in IJB allocation letters. In addition a quality improvement approach was being taken to primary care prescribing to mitigate the financial pressure with a focus on cost and variation. This work was being taken forward by the effective prescribing forum.

3.5 The Board were advised that it had been reported at the most recent meeting of the Finance and Resources Committee that all residual recurrent reserves had been allocated to the bottom line. The current financial gap was £22.4m and this excluded any provision for the use of the independent sector to reduce waiting times which would impact on performance as discussed within the LDP. It was noted that further discussions around this position would be held with the Scottish Government later in the day.

3.6 The Board received a summary of the cost pressures facing the system as well as sources of funding and their allocation to move to a balanced financial position. The

National Resource Allocation Committee (NRAC) position was also discussed. It was noted that the efficiency savings proposal of 2% was consistent with previous years delivery with it being unlikely that an increased level could be achieved without impacting on services. It was noted that a sustainability and value approach was being driven nationally and that this moved away from the efficiency and productivity focus in previous years and reflected the need to do more with less. In that respect non cash and productivity opportunities were important and the Scottish Government allocation letter was clear about expectations for inclusion in improvement plans.

3.7 The Board noted that work was continuing on all fronts in respect of reducing the financial gap with focus in particular around prescribing, junior doctor pressures and nursing. It was too early to predict a breakeven financial position particularly within the context of all reserves having been applied to the financial bottom line.

3.8 The point was made in respect of the LDP and the performance areas why the Board was not putting resource into high risk areas and whether the Board was satisfied that it had enough influence in this respect. The Director of Finance commented that she did not think that resources were being allocated to where they should be and that each year there was a need to respond to pressures. In that respect in the current year there had been an attempt to skew investment towards IJBs and primary care to reduce pressure in acute services by giving IJBs less of an efficiency gap. The point was made that the solution was about more than financial dialogue and needed to include quality improvement etc.

3.9 The point was made that there was a need to be clear about the outcomes that needed to be achieved and the need for appropriate challenge and that if these were clear then there were opportunities to make more nuanced decisions. The point was made it was not always easy for Board members to understand the means against which performance had been risk assessed.

3.10 The Board were advised that between 60-80% of cancer cases were preventable by looking at risk factors and that small interventions particularly in areas like alcohol intervention could have significant impact and that there was a need to focus investment on where evidence was available. The Director of Public Health and Health Policy commented that Scotland had a below average spend on prevention and she would be concerned if this were to be reduced further. It was noted that this and related debate moved into the realistic medicine agenda and was further complicated when debate moved into expected outcomes from a patient perspective.

3.11 The Chairman commented that the question around the influence of the Board was a fundamentally important point although he felt that currently the system was not properly equipped to answer the question posed although there was a need for assurance that decisions were properly made. He commented that historically and correctly that the Board had been driven down an imposed target setting route and that performance targets had been discussed in the past in respect of the validity of targeting of resources. The Chairman thought that there was a need for more scrutiny around this area.

3.12 The Board were reminded that thought the development process of ‘Our Health Our Care Our Future’ that criteria for investment and resourcing had been established

and it might be worth revisiting this in respect of the points made at the current meeting.

3.13 The Board were advised in terms of the generalality of the LDP that this was a long document and was still in draft form and was therefore an iterative live document which would be able to respond to Government policy as it was published. The point was made in response to a comment about the importance of realistic medicine that this was reflected in the LDP although more detail might be required. It was noted that the inaugural meeting of the Primary Care Programme Board would be held later in the day where the availability of funds to tackle prescribing and workforce as well as other issues would be discussed. It was noted that the LDP majored on workforce as one of its key priorities and that the regional approach allowed a different view on this to be taken. The Board noted that in the current LDP that this was the first time that research and development had a strong emphasis with the intention being that this should be used to drive future business. Other key aspects of the LDP were explained and discussed by the Board.

3.14 The Board noted that scheduled care and unscheduled care continued to need to be considered given the intention that there would be no investment in the private sector and there would be a need to consider how to manage the current capacity. The Board received an update on the Scotland wide position in respect of waiting times, outpatients and day case activity. It was noted that NHS Lothian would continue to invest in in-house waiting time activity but not the independent sector. It was noted that an Outpatient Programme Board had been established and was Chaired by the Medical Director which would look at areas of significant redesign. Proactive communication with the service and patients would continue. The Board were advised that an exercise was underway looking at how to risk assess patients on waiting lists and how to target resource to the highest risk areas. A clinically driven framework was being developed and would be discussed further at the meeting with the Scottish Government later in the day.

3.15 The point was made that the continued annual focus on finances and performance was a misnomer within the context of developing a more strategic approach. It was felt that the current LDP did not make clear what was being achieved in the current year and would benefit from the inclusion of a matrix about what the plan hoped to achieve and what the measure of success would be. As currently framed it was suggested that the LDP represented a general description of activity. The Board were advised that the format of the report was designed to meet Scottish Government requirements. The LDP linked to the corporate objectives in terms of measureability around performance. The suggestion was made that at the end of each section of the LDP it should be made clear what the specific targets were.

3.16 An update was provided on the Boards ability to deliver the 73 recommendations contained in the maternity neonatal plan with a key challenge for the Board being around the availability of midwifes.

3.17 The Chairman agreed that currently the LDP was suffering from extensive narrative with there being a need to quantify actions and outcomes. The Board noted that the LDP in final format would be submitted to the Scottish Government in September and could therefore be amended to reflect debate and be brought back to the next Board meeting. It was agreed that key performance indicators would be developed

to reflect the complexities of interdependency and to inform the project plans. Any updated information available since the production of the existing plan would be incorporated in future iterations.

3.18 The Board discussed in detail the paragraphs in the covering paper relating to key risks and the risk register. It was noted that at the moment no risk schedule was being presented to the Board as it was under development. The risk schedule would come forward to the next Board meeting at part of the general update on the LDP.

3.19 The Board discussed the complex global perspective of workforce development and questioned the understanding of the composition of skills within the NHS and the availability of appropriately skilled staff moving forward into the future. In response it was suggested that there was a need to look at examples of where workforce planning was done well and use this in other areas. It was suggested that some of the work would be informed by research and development and the creation of multi professional teams. Specific work was being undertaken looking at modernising the outpatient model. The Board noted that in workforce terms the default position was often to move to a nurse led solution without recognising that nursing staff were not always available. In that respect workforce planning needed to reflect services. The Board noted that a Workforce Development Board had been established. Individual IJBs would also need to produce workforce plans.

3.20 The Chief Executive commented in respect of the global workforce that a view of a lot of younger generation medical staff was that they were generally looking for a work-life balance as an aspiration in their career planning. In addition some medical staff took significant career breaks with there also being a reduction in the level of fulltime working with this being reflected across a number of specialties including general practice. The Board were advised that there was a need to recruit an increasing number of Scottish domiciled staff who wanted to work and stay in Scotland and that this position was referenced in the National Workforce Plan. The point was made that with the further development of artificial intelligence that medical staffing would be a significant area of impact. A significant workforce challenge was to create care capacity in social care to support people to live in their own homes. The Chief Executive commented that whilst a lot was happening that there was not yet a global view of the workforce and this was one of the challenges that the National Workforce Plan would be trying to respond to.

3.21 The Board agreed the recommendations contained in the circulated paper and agreed that an updated LDP would be brought forward to the next meeting.

4. Corporate Objectives 2017/18

4.1 The Board noted that the content of the previously discussed 2 papers had informed the production of the corporate objectives for 2017/18. It was noted that in the previous year no corporate objectives had been produced with the intention being to utilise the LDP although this approach had not been as successful as intended. In the current year there had been an attempt to distil the LDP into the corporate objectives and thereafter personal objectives for Executive Directors. It was noted that in a departure from previous years that complaints and patient feedback now featured as a specific objective for each individual Executive Director given the

impact on the whole system agenda. It was felt that the six objectives detailed in the circulated paper covered the issues discussed earlier in the meeting.

4.2 The Chief Executive commented that at one level there was a level of greater granularity around the LDP although it had been felt to be important to distil this into a smaller number of objectives. He pointed out that the Boards vision statement in itself covered at least 3 of the corporate objectives and he felt this was a correct balance. The remaining 3 corporate objectives covered other significant issues including engagement with staff and the development of a new culture. The Chief Executive commented that if agreement could be achieved around the corporate objectives then he would see these being used as a key communication tool for use in internal and external presentations. It was agreed there was a need to articulate the risk of the regionalisation agenda.

4.3 The Board discussed the prioritisation of e-Health with it being noted that this was a key constraint within primary care. The Medical Director undertook to progress this offline. The Board felt that there was also a need to include within the objectives a requirement for individual performance objectives with staff and this issue would be picked up with the Interim Director of Human Resources and Organisational Development.

4.4 The point was made that there was a need to be cognisant of the presentation of the corporate objectives and their intended audience. In that respect it was agreed to reorder the objectives putting objective 3 and 5 at the forefront.

4.5 The Board agreed that reference to IJBs should be made more specific within the objectives. It was noted that IJB Chief Officers through the Corporate Management Team had inputted in to the production of the corporate objectives and understood the interfaces with the IJB position.

4.6 The point was made that there remained a misconception that shifting the balance of care would make savings and the previous reference to the Nuffield report was referenced. The point was made that there was a need to invest in the community to create capacity to reduce hospital activity. In respect of investing in the community it would be important to make an effort not to reinforce a wrong assumption around future cost releases.

4.7 The Board noted the need to reflect on shifting the balance of care to let hospitals operate at 85% occupancy. Reference was made back to previous debate about the need to reduce beds to release financial savings and the fact that this position was reflected in the corporate objectives. The point was made that within the objectives there should be an attempt to be less specific around percentages and to reflect the objective by providing examples of desired outcomes.

4.8 A further amendment to the corporate objectives was agreed in respect of the need to have more focus around participation and engagement with people in order to encourage them to take responsibility for their own health. This would need work with the wider population. The corporate objectives would be amended accordingly.

4.9 The Board agreed the recommendations contained within the circulated paper subject to the corporate objectives reflecting the amendments suggested at the meeting.

5. Quality and Performance Improvement

5.1 The Board were advised that informed decisions needed information and analytical support. Information needed to be relevant to key partners and that in future iterations of the paper attempts would be made to link information in graphical format.

5.2 The Board received a detailed report on performance and mitigating action in respect of the cardiac arrest rate; children and adolescent mental health services; outpatient waiting times; surveillance endoscopy and the complaints 20 day response which was subject to a separate Board paper.

5.3 The Board noted the Chief Quality Officer's aspirations around the future use of information and his desire to internally enhance quality improvement programmes around data capture, analysis and presentation into services. This would ensure that information presented to the Board was relevant and reflected key initiatives like primary care and realistic medicine. There was a need to move to a position of having local ownership of data.

5.4 In terms of recommendation 2.1.2 it was suggested that this could be amended to more accurately reflect the reality of the position around the Board Committee assurance process and in particular the fact that on at least one occasion the Healthcare Governance Committee had reached a 'no assurance' provided position in respect of the complaints handling process.

5.5 The Board noted that the science of applied probabilities against indicator required two separate issues the first of which was sustainability and the other was a reflection of the magnitude of improvement both of which could be graphically presented. The Chief Quality Officer advised that he was cautious about extending the period of performance reporting as it often took a long time to recognise improvement and that this approach might slow down the tempo of change.

5.6 The point was made that future iterations of the paper should include introductory comment to set the context as there would be clear reasons why some targets had not been met. The outcomes of the national work undertaken by Sir Harry Burns would where appropriate feature in future reports.

5.7 The Chief Executive in response to a question commented that previously the Board had increased the parameters of what was regarded as a waiting times acceptable offer to 97 miles and in that regard this meant that the Golden Jubilee Hospital in Clydebank was routinely used for appointments. In general people were happy to travel to the Golden Jubilee Hospital which had a low DNA (did not attend) rate. The legislation and national guidance around waiting times was clear around the need to source and look at capacity elsewhere including in extremis in Europe although this option had not been used in Lothian although patients had been treated in other

Boards and in England. The point was made that in some specialties like cancer patients were best managed by a single team.

5.8 The Board agreed that the content and structure of the performance report had improved. The confidence in governance terms remained around the consistency in the way that information was presented which did not allow the Board to get to the nub of the problem. The information was still not felt to be robust enough in terms of providing assurance that issues were being managed on an ongoing basis. The point was made that up to date information was needed when funding decisions were being taken. A question was raised about whether the available data was sophisticated enough to allow horizon scanning. It was noted that the development of such data was part of the ongoing work around demand and capacity. The Chief Quality Officer confirmed that such data could be produced.

5.9 The Board agreed the recommendations contained in the circulated paper subject to the caveats made around recommendation 2.2.

6. Complaints and Feedback

6.1 The Board noted that following previous concerns raised by the Healthcare Governance Committee that a project plan had now been produced that aligned to the Short Life Working Group Chaired by Mrs Hirst reporting into the Healthcare Governance and Risk Management Committee. It was noted that additional capacity had been brought in to support the in-house team where the largest piece of ongoing work was around what the model would look like to support the implementation of the new legislation.

6.2 The Board noted that significant performance improvement had been made around the 3 day acknowledgement requirement and also the Royal Infirmary of Edinburgh overall process. It was noted that the new process around the complaints procedure had been live since 1 April 2017 and that NHS Lothian was in the process of implementing the requirement and had been required to submit a progress checklist to the Scottish Government. The Board received a tabled paper which updated on the current position.

6.3 The Board received an update report on continuing work with the Scottish Public Services Ombudsman and were advised that a recent workshop on maternity and woman and children services had been productive. The Board noted the progress being made around prison services where work around improving the early intervention requirement had been put in place.

6.4 The Board noted that discussions had been held around organisational development and links with the value statement in respect of the need for ownership of the complaints process to be embedded in culture and behaviours as part of routine daily business.

6.5 The Board noted that a full report on the implementation of the new legislation would be brought back as currently a hybrid model was in operation. The Board noted that having a Non Executive Board member chairing the working group was useful in

terms of objectivity and suggesting the best way to communicate with staff and other partners.

6.6 The Board noted that the following key workstreams required to be progressed. The first was the need to implement the new procedures as detailed in the legislation. Thereafter there was a need to engage staff and patients around the public facing document. The checklist back to the Scottish Government required to be completed to recognise compliance with the new legislation although primary care still remained an area of challenge. GPs and dentists and others were required to provide information which was not supported by internal infrastructure. Finally there was a need to consider and agree the proper infrastructure to support the complaints team.

6.7 Mrs Hirst commented as Chair of the working group that she was interested to hear the views of the Board about the format of the report which had moved to a more high level overview with the Healthcare Governance Committee receiving a more detailed report. She commented that the two key issues facing the service at the moment were to satisfy the SPSO that the complaints procedure within NHS Lothian was fit for purpose to include evidence of a learning culture. There was also a requirement to satisfy him around the investigative process being applied to complaints. As part of the new legislative process there would be a need to work with Council colleagues and IJBs and work had commenced in this area.

6.8 The Board agreed the recommendations contained in the circulated paper.

7. Drug and Alcohol Funding 2017/2018

7.1 The Board noted that drug and alcohol funding had represented the first large challenge of integration. The Scottish Government had reduced the funding available by 23% although its guidance had stated that Health Boards and others were required to maintain 2015/16 funding levels. In order to progress this requirement a substance misuse collaborative process had been adopted to look at the current spend profile for services. This had led to robust discussions which had usefully concluded the areas where further provision was needed. It was noted that NHS Lothian had a responsibility for the prison population within its area in totality in order to avoid postcode inequalities.

7.2 The Board noted that the process had considered inpatient facilities at the Ritson Clinic where beds had reduced from 12 to 6 through the provision of safe community detoxification facilities for patients. An update report was provided around the funding position in respect of the alcohol brain damage unit and the requirement for community alternatives to be identified if IJBs did not want to contribute to the overall funding of the service. The Edinburgh IJB had agreed to consider 75% funding.

7.3 The Board noted that this was a complex landscape and further work was required. The position paper had been brought to the Board for discussion around the process for funding and risk tolerance.

7.4 The point was made that the reduction in funding had forced a focus on ensuring that drug and alcohol services were provided efficiently. A concern was raised that each year the LDP looked at pressures and despite the Scottish Government expectations

around this service alcohol and drug funding had never featured as an issue in the LDP. Reference was made to previous Board debate around the prevention agenda. The point was made that the Board had not received this level of detail because of the governance process which meant that these issues should be discussed at IJB level. The Board were reminded that in the previous year funding had been sustained by NHS Lothian and that in the current year partnerships would need to discuss through IJBs their position which if justified could result in a reflection in the current LDP.

7.5 The Board noted that assessment work needed to be completed looking at needs in respect of harm reduction which would allow a focus on what the forward position should be for IJBs.

7.6 The Board agreed the recommendations contained in the circulated paper.

8. Date and Time of Next Meeting

8.1 The next meeting of Lothian NHS Board would be held at 9.30am on Wednesday 21 June 2017 in the Scottish Health Services Centre, Crewe Road, Edinburgh.

9. Invoking of Standing Order 4.8

9.1 The Chairman sought permission to invoke Standing Order 4.8 to allow a meeting of Lothian NHS Board to be held in private. The Board agreed to invoke Standing Order 4.8.

DATA LABEL: PUBLIC

West Lothian Council

HEALTH AND CARE POLICY DEVELOPMENT AND SCRUTINY PANEL

WEST LOTHIAN INTEGRATION JOINT BOARD

REPORT BY DEPUTE CHIEF EXECUTIVE

A. PURPOSE OF REPORT

To update members on the business and activities of West Lothian Integration Joint Board.

B. RECOMMENDATION

To note the terms of the minutes of West Lothian Integration Joint Board dated 20th April 2017 in the Appendix to this report.

C. SUMMARY OF IMPLICATIONS

I	**Council Values**	Focusing on our customers' needs Being honest, open and accountable Working in partnership.
II	**Policy and Legal (including Strategic Environmental Assessment, Equality Issues, Health or Risk Assessment)**	Council requires the activities of certain outside bodies to be reported to elected members on a regular basis, as part of its Code of Corporate Governance.
III	**Implications for Scheme of Delegations to Officers**	None.
IV	**Impact on performance and performance Indicators**	Working in partnership.
V	**Relevance to Single Outcome Agreement**	We live longer, healthier lives.
VI	**Resources - (Financial, Staffing and Property)**	None.
VII	**Consideration at PDSP**	Reported to Health & Care PDSP for noting.
VIII	**Other consultations**	None required.

D. TERMS OF REPORT

On 29 June 2010 the Council Executive decided that the activities of certain outside bodies should be reported within the council to ensure all elected members are aware of the business of those bodies and to help to ensure their activities are more effectively scrutinised.

In accordance with that decision the business of West Lothian Integration Joint Board was to be reported to this meeting by the production of its minutes. The relevant documents are produced in the Appendix to this report.

E. CONCLUSION

This report ensures that members are kept appraised of the activities of West Lothian Integration Joint Board as part of the council's Code of Corporate Governance.

F. BACKGROUND REFERENCES

West Lothian Council Code of Corporate Governance.

Council Executive, 29 June 2010

Appendices/Attachments:	Minutes of the meetings of West Lothian Integration Joint Board held on 20th April 2017
Contact Person:	Jim Forrest, Depute Chief Executive 01506 281977 Jim.Forrest@westlothian.gov.uk
CMT Member:	Jim Forrest, Depute Chief Executive
Date:	24th August 2017

MINUTE of MEETING of the WEST LOTHIAN INTEGRATION JOINT BOARD held within STRATHBROCK PARTNERSHIP CENTRE, 189 (A) WEST MAIN STREET, BROXBURN EH52 5LH, on 20 APRIL 2017.

Present

Voting Members - Danny Logue (Chair), John McGinty, Anne McMillan, Martin Hill, Alex Joyce, Lynsay Williams.

Non-Voting Members – Ian Buchanan (Stakeholder Representative), Jim Forrest (Director), Mairead Hughes (Professional Advisor), Jane Houston (Staff Representative), Jane Kellock (Chief Social Work Officer), James McCallum, Patrick Welsh (Chief Finance Officer), Bridget Meisak (WL Vol Sector Gateway).

Apologies – Elaine Duncan, Mary-Denise McKernan, Martin Murray.

In Attendance – Alan Bell (Senior Manager, Communities and Information, WLC), Carol Mitchell (NHS Lothian), Marion Barton (Head of Health Services), Bridget Meisak (WL Voluntary Sector Gateway), Kenneth Ribbons (IJB Internal Auditor), Carol Bebbington (Senior Manager Primary Care and Business Support).

1. DECLARATIONS OF INTEREST

Danny Logue declared a non-financial interest as an employee of NHS Lothian.

2. MINUTES -

(a) The West Lothian Integration Joint Board approved the minute of its meeting held on 14 March 2017.

(b) The West Lothian Integration Joint Board noted the minute of the meeting of the Audit Risk and Governance Committee held on 6 January 2017.

(c) The West Lothian Integration Joint Board noted the minute of the meeting of the Strategic Planning Group held on 19 January 2017.

3. IJB ANNUAL ACCOUNTS COMPLIANCE

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer setting out final accounts requirements and timescales for the IJB and proposed reporting arrangements to meet compliance with the Local Authority Accounts (Scotland) Regulations 2014.

The Chief Finance Officer advised that he was responsible for preparing the financial statements in accordance with relevant legislation and the

Code of Practice on Local Authority Accounting. This required the maintenance of proper accounting records and the preparation of financial statements which gave a true and fair view of the state of affairs of the IJB at 31 March 2017.

The EY Annual Audit Plan outlined requirements and timescales for the annual accounts process. The Local Authority Accounts (Scotland) Regulations 2014 required that the unaudited annual accounts, including the governance statement, were submitted to the appointed external auditor no later than 30 June each year. The regulations included a number of provisions in relation to the unaudited accounts including a requirement for the accounts to be considered by the Board, or a committee who remit included audit or governance, prior to submission to the external auditor.

The 2014 regulations required the audited accounts to be approved by 30 September. Following approval, and by 31 October at the latest, the audited annual accounts required to be signed and dated by the IJB Chair, Director and Chief Finance Officer, and then provided to the auditor.

It was therefore proposed that the annual audited accounts along with Audit Scotland's audit report be presented to the IJB for consideration and approval at its scheduled meeting on 26 September 2017.

It was recommended that the Board:-

1. Note the requirements set out in the report.

2. Note that the unaudited annual accounts would be considered by the IJB on 27 June 2017.

3. Note that the audited annual accounts would be considered for approval by the IJB at its meeting on 26 September 2017, allowing the deadline of 30 September to be met.

Decision

To note the terms of the report.

4. EXTERNAL AUDIT PLAN 2016/17

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer attaching a copy of Ernst and Young Annual Audit Plan 2016/17

The Chief Finance Officer advised that, as set out in the EY audit plan, auditors in the public sector gave an independent opinion on the 'truth and fairness' of the financial statements. Section three of the plan outlined EY's approach to the audit of the financial statements and significant risks identified.

Section 6 of the plan set out EY's audit team, timeline and deliverables. The

auditors would aim to certify the annual accounts by 30 September 2017. In terms of the audit fee, it was noted that due to the nature of the IJB, with this being the first full year of operation, no expected fee had been set centrally yet. Subsequent to this, a fee had been proposed by EY but this was still subject to agreement and further discussion with EY. Appendices to the plan set out audit independence and objectivity requirements and communications that would be provided to the IJB.

It was recommended that the Board note the external auditors' 2016/17 annual audit plan.

Decision

To note the external auditor's 2016/17 annual audit plan and that it had been approved by the Audit, Risk and Governance Committee subject to completion of the audit fee setting process and acceptance of the fee proposed by EY.

5. INTERNAL AUDIT ANNUAL REPORT

The Board considered a report (copies of which had been circulated) by the Internal Auditor advising the IJB of the Internal Audit Annual Report for 2016/17.

The Internal Auditor informed the Board that he was required to submit an annual report timed to support the annual governance statement. This would include:

- An annual internal audit opinion on the overall adequacy and effectiveness of the IJB's governance, risk and control framework;
- a summary of the audit work from which the opinion was derived;
- A statement on conformance with the PSIAS and the results of the internal audit quality assurance and improvement process.

The annual report, a copy of which was attached the report, fulfilled the requirement.

The IJB was required to conduct, at least once in each financial year, a review of the effectiveness of its system of internal control. This requirement had been discharged firstly, by the risk based audit work undertaken during 2016/17 as set out in the annual report and secondly, by the report on annual accounts compliance prepared by the Chief Finance Officer.

It was recommended that the Board:

- consider the contents of the annual report, in particular the internal audit opinion on the framework of governance, risk management and control.
- refer the annual report to the Audit, Risk and Governance

Committee for further consideration.

Decision

1. To note the terms of the annual report; and

2. To refer the annual report to the Audit, Risk and Governance Committee for further consideration.

6. ADDITIONAL ONE-OFF INVESTMENT FOR SOCIAL CARE/HEALTH PRIORITIES

The Board considered a report (copies of which had been circulated) by the Director providing details of one off funding agreed by West Lothian Council for Alcohol and Drug Partnership (ADP) Technology Enabled Care (TEC) investment.

The Board was informed that additional one off funding of £296,000 had been approved by the Council for social care/health initiatives. The use of the funding had subsequently been agreed by Council Executive on 28 March 2017 as relating to IJB functions and as an additional budget contribution to the IJB.

Health and Social Care officers had taken account of how this additional £296,000 should be utilised to support health and social care investment priorities, including taking account of the one off nature of the funding. Based on this, the following two measures had been agreed by Council Executive on 28 March 2017:-

1. Additional investment to commissioned addiction services to partially offset reduced specific Scottish Government funding for Alcohol and Drug Partnerships (ADPs).

2. Additional investment to support the Technology Enhanced Care programme (TEC)

The report recalled that Scottish Government funding for ADPs had been reduced by 23% in 2016/17. Part of the additional one off funding had been allocated to partially offset reductions to commissioned addictions services. A number of the service delivery activities had just been tendered with revised service specifications and reduced overall contract sums. It was not possible to make any change in these contracts without contravening European Procurement rules.

It was proposed that the restoration of funding be applied to the following two commissioned services for 2017/18:-

Therapeutic Support Service - £111,533

Recovery Service - £42,426

The outcomes achieved through this investment would be closely reviewed during 2017/18 and the ongoing sustainability of this investment would be

assessed as part of the overall 2018/19 budget planning process for social care and health services.

The report went on to advise that West Lothian had been innovative in exploring options to enhance investment in assistive care technologies and this was a key investment priority that would help meet future care demands and enable elderly clients to stay in their own homes. It was felt that the programme would benefit significantly if additional funding of £142,041 was added to the programme for 2017/18. This was likely to see a range of planned initiatives come on-stream at a much earlier state than would otherwise have been possible.

Both addiction services and the Technology Enhance Care programme were services which the IJB provided already under the Strategic Plan and it was proposed that the funding of £296,000 be made available to the IJB by Council for the purposes as outlined in the report with the IJB, through the Chief Officer, giving a supplementary Direction to Council to proceed on this basis.

It was recommended that the IJB agree that a further Direction be issued to West Lothian Council in respect of additional one off funding of £296,000 for ADP and TEC related investment.

Decision

1. To agree the recommendation by the Director that a further Direction be issued to West Lothian Council in respect of additional one off funding of £296,000 for ADP and TEC related investment.

2. To recognise that future proposals relating to the allocation of funding would be subject to a planning process that would take account of the entire budget and would be supported by the priorities outlined in the Strategic Plan.

7. STATUTORY ANNUAL PERFORMANCE REPORT

The Board considered a report (copies of which had been circulated) by the Director presenting the outline for the Annual Report 2016/17 and how this would be developed for publication by 31 July 2017.

The Senior Manager Primary Care and Business Support presented the report, advising that the Annual Performance Report 2016/17 as outlined in Appendix 1 to the report was structured according to the national health and well being outcomes and would include key performance measures, a performance assessment and practice examples for the reporting period.

Performance measures would be drawn from the Core Suite of Integration Indicators. Where appropriate the performance measures would be 'RAG-rated' using a traffic light system for illustrating progress against expected performance.

The Board was informed that the annual Performance Report 2016/17 would include sections on governance and decision making, financial

performance, Best Value, inspection findings, the annual review of the Strategic Plan and locality arrangements.

It provided the opportunity to reflect on the year and to celebrate the achievements delivered by employees and partners. It was also a chance to highlight new ways of working within services which focused on maximising choice and control for individuals, families and carers, tackling inequalities, long term conditions and working alongside employees, partners, professionals, third sector and communities to bring about change.

For each section the report would provide an assessment of performance and highlight examples of good practice. To this end the members of the Strategic Planning Group and Integration Joint Board were invited to submit examples for inclusion in the report.

Finally, it was noted that the Draft Annual Performance Report would be brought to the Board for comment and approval prior to publication in July 2017.

The Integration Joint Board was asked to:

1. Note the contents of the report.

2. Comment on the proposed Annual Performance Report outline

3. Consider examples of good practice for inclusion in the report.

Decision

To note the terms of the report and to note that examples of good practice were invited from Board members.

8. ARRANGEMENTS TO LIAISE AND CO-OPERATE WITH PARTNER ORGANISATIONS

The Board considered a report (copies of which had been circulated) outlining the arrangements in place to co-operate with Partner bodies to help achieve IJB objectives and outcomes.

The Board was informed of the requirements of Section 22 of the Public Bodies (Joint Working) (Scotland) Act 2014, and the West Lothian Integration Scheme in relation to collaboration, co-operation and sharing of relevant information.

The Director advised that there were a number of forums in place currently which were meeting the need for co-operation and collaboration, and these were listed in the report.

In addition to those listed, it was worth noting that there were the following national groups in place in relation to IJBs:

- Chief Officer's Health and Social Care Scotland. This group ensured

there was collaboration and a sharing of information at a national level between IJB chief officers and other partner organisations including the Scottish Government.

- Chief Finance Officers Network. This group met regularly to ensure that was collaboration and a sharing of information at a national level between IJB Chief Finance officers and other partner organisations including the Scottish Government.

The Board was asked to note the contents of the report.

In response to questions raised, the Director undertook to ascertain (i) whether a group (chaired by Carol Harris) was still in operation and (ii) the appointed staff side representative on the Primary Care Investment and Redesign Board.

Decision

To note the terms of the report.

9. EQUALITIES MAINSTREAMING REPORT AND EQUALITY OUTCOMES 2017 - 2021

The Board considered a report (copies of which had been circulated) by the Director attaching a copy of the Integration Joint Board's Equality Mainstreaming Report and Equality Outcomes 2017-2021.

Under the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012, public bodies were required to develop and publish an equality mainstreaming report and a set of equality outcomes and to report on progress against those every two years.

The Board was informed of what West Lothian IJB was doing and what it planned to do to mainstream equality. It also set out four equality outcomes for the IJB to work towards over the coming four years. If agreed, the mainstreaming report and equality outcomes would be published ahead of the deadline of 30 April 2017 and progress against this would be published in April 2019.

It was explained that equality outcomes were results intended to achieve specific and identifiable improvements in people's life chances. The IJB's Equality Outcomes for the four year period 2017-2021 were set out in the final section of Appendix 1 to the report. The outcomes had been developed through evidence gathering and engagement work as part of the development of the strategic plan. Each outcome had been designated to a responsible officer or group.

It was recommended that the Board note the report and agree the Equality Outcomes for 2017 – 2021.

During discussion, the Board heard a suggestion by Jane Houston relating to Appendix 1 to the report at page 10. It was suggested that "policies" should read "governance". In response, officers undertook to

amend the document as suggested.

Decision

1. To note the terms of the report.

2. To agree the Equality Outcomes for 2017-2021, but subject to amending "policies" to "governance" as suggested.

10. COMMUNITY PLANNING PARTNERSHIP

The Board considered a report (copies of which had been circulated) by the Director providing an overview of the IJB relationship with the West Lothian Community Planning Partnership and the various groups and work streams associated with the Partnership.

The Board was informed that the West Lothian Community Planning Partnership (CPP) was structured to deliver the Single Outcome Agreement through a number of partnership groupings. These were:

The Community Planning Partnership Board
The Community Planning Steering Group
Four thematic Forums

1. Community Safety
2. Health and Well Being
3. Economic
4. Environment

Each grouping of the partnership had relevant representation from partner organisations based on the business of that group. This included the SOA enabler groups and related development work streams.

The IJB was represented by the Chief Officer and Senior Managers on the CPP Board; CPP Steering Group, Community Safety Strategic Steering Group and the Anti Poverty Strategy Board. In addition, members of the senior management team were involved in the CPP work streams focussed on resource aligning; resources, data and information; and enabling collaborative leadership.

Finally, it was noted that the CPP received regular reports on the health and well being outcomes and had received presentations on our approach to health and social care integration and the IJB Strategic Plan. Through the various Boards and groups representatives of the IJB ensured the CPP were actively engaged in the work of the IJB and could contribute fully to the development of plans and approaches to ensure alignment with the SOA and the National Health and Well Being Outcomes.

It was recommended that the IJB:-

1. Receive the report;

2. Note that the IJB was a member of the Community Planning Partnership

3. Note that the Chief Officer and Senior Managers represented the IJB across the activities of the Community Planning Partnership

4. Note the joint working with the Community Planning Partnership in terms of Strategic Planning and Locality Planning

Decision

To note the terms of the report.

11. WORKPLAN

A copy of the Workplan had been circulated for information.

Decision

To note the Workplan.

Chair's Closing Remarks

Referring to the forthcoming local government elections in May 2017, the Chair thanked officers and IJB members for their support and co-operation during the current term of administration.

West Lothian Council

HEALTH AND CARE POLICY DEVELOPMENT AND SCRUTINY PANEL

TOGETHER FOR HEALTH UPDATE

REPORT BY HEAD OF PLANNING, ECONOMIC DEVELOPMENT AND REGENERATION

A. PURPOSE OF REPORT

The purpose of this report is to update the panel on the activity of Together For Health (T4H).

B. RECOMMENDATION

It is recommended that the panel notes and comments on the contents of the report and the progress to date, in particular:

1. the continued development of T4H in Fauldhouse; and
2. the transfer of key activities and interventions to local partners.

C. SUMMARY OF IMPLICATIONS

I	**Council Values**	Focusing on our customers' needs; Being honest, open and accountable; Making best use of our resources; and Working in partnership.
II	**Policy and Legal (including Strategic Environmental Assessment, Equality Issues, Health or Risk Assessment)**	An equality impact assessment has been completed and action points identified.
III	**Implications for Scheme of Delegations to Officers**	None.
IV	**Impact on performance and performance Indicators**	Together for Health will have a positive impact on relevant performance indicators linked to improving health and well-being within the Armadale and Fauldhouse localities.
V	**Relevance to Single Outcome Agreement**	We live longer, healthier lives.
VI	**Resources - (Financial, Staffing and Property)**	Managed within existing resources from Community Regeneration.
VII	**Consideration at PDSP**	Previous report to the Heath & Care PDSP – 02

June 2016.

VIII Other consultations None required.

D1 Background

Together for Health (T4H) is a community based project, delivered by West Lothian Council, which works in partnership with a range of local organisations, businesses and community groups to promote healthy lifestyles. The project delivers a variety of activities and events, targeted and children and families, encouraging people to 'Move More and Eat Better', with the overall aim of reducing childhood obesity.

Key messages of the project include the promotion of a balanced, affordable diet; encouraging children and families to be more physically active; and encouraging less time spent doing sedentary activities. The project is involved in a number of partnership initiatives designed to support changes in behaviour which promote a healthy weight, and to increase awareness of healthy lifestyles in the community.

Initially the project was set up and based in Armadale. In the 2015 T4H programme was launched in Fauldhouse. The T4H methods have be tailored to this local area to achieve the same outcomes as identified in Armadale. The project is focused on a number of key themes, and interventions have been developed within each. These themes are nutrition, physical activity, local activity and capacity building**.**

The initiative was originally funded by NHS Lothian and overseen by a consultant paediatrician. The council has continued to deliver the project from within internal resources since 2016.

D2 Nutrition

Fruity Friday

The Fruity Friday programme, which is delivered in eight schools on the last Friday of every month, is designed to increase fruit consumption of local children. Feedback from schools shows that children are eating more fruit that they did previously and have tried fruit that they hadn't tried before as a result of this programme.

Discussion is currently underway to identify local businesses and potential sponsors of the programme who could contribute financially to ensure its long term sustainability.

Smoothie Bikes

Three new smoothie bikes have been purchased this year, adding to the two bikes already owned by the project. The new bikes will be shared by the schools in the Armadale and Blackridge ward, allowing each school to have use of one for a full school term. This enables planning by the schools, making it easier for them to incorporate healthy activities into their timetables.

The two existing bikes will be available in the same way for the primary schools in Fauldhouse. The schools will be less reliant on T4H as a result of this additional resource.

D3 Physical Activity

Run for Fun

The Run for Fun is now a key signature event for the T4H project. This annual event provides both a 2km and 5km walk or run for families to take part in, delivered in both Armadale and Fauldhouse. Armadale has welcomed over 1600 people to the event since 2011.

In 2016, organisation of the event in Armadale was transferred to local business and long term T4H partner, Dream Fitness. The 2017 event, held on 28 May, was the first organised by Dream fitness and supported by T4H, and was extremely well attended, with approximately 400 participants taking part across both distances. There was also a partnership with Armadale Gala Day this year which saw the gala marathon, an event for P1-S6 pupils, being delivered alongside the Run for Fun.

T4H has been working to establish a similar local delivery model in Fauldhouse, with the local partner GRC Triathlon organising this year's event. This will be the third year the Fauldhouse Run for Fun has taken place and it is now viewed as an established event in the community calendar. An average of 100 runners have taken part in each of the first two events held.

In addition to the two T4H target areas, a Run for Fun event has also been delivered in Addiewell since 2013. This event was originally delivered by the Community Regeneration team, based on the T4H model, but has been gradually taken over by the Addiewell community, with last year's event fully organised by the gala committee and staff from the Pitstop. This is a great example of capacity building within communities.

The first Stoneyburn Run for Fun will take place on 26 August 2017. This is also based on the original T4H model but is being fully planned and delivered by Stoneyburn & Bents Future Vision Group with support from GRC Triathlon.

Santa Parade

The Santa Parade encourages physical activity during the festive period by asking families to walk a mile with Santa and his sleigh through the local community. The event is aimed at those who would normally not walk a mile and strongly encourages family participation. The event distributes health promoting literature and is supported by local people and businesses. The Santa Parade took place for the third time in Fauldhouse in 2016, with over 400 participants, but couldn't be delivered in Armadale to due to a number of external factors.

As with the Run for Fun, this model has also been replicated in other local communities. It has taken place in Addiewell for the past five years and in Stoneyburn for four. Both communities are now organising these events on their own, with minimal support from the council, and have grown them year on year. Over 500 tickets were sold for the Stoneyburn event in 2016.

Consideration will be given to other communities where events such as the Santa Parade and the Run for Fun could be established. Local regeneration steering groups would provide the vehicle for delivering such activity.

Jolly Joggers

This weekly activity provides local people of Armadale and Fauldhouse the opportunity to attend a free exercise and support group that aims to encourage people of all levels to take the first steps to becoming more active. The programme is suitable for beginners and more experienced runners, and is supported by up to three jog leaders. An average of eight to ten people take part in this free activity each week.

D4 Local Businesses and organisations

Local businesses are key partners in the delivery and support of many of the T4H programmes and interventions. Their support is also vital in terms of the future sustainability of a number of signature events.

Scotmid

Scotmid have supported the project since its inception, they provide support to T4H events in both Fauldhouse and Armadale by the provision of water, fruit and healthy snacks. Smoothie bike and information sessions are held in-store to promote awareness of the project and upcoming events.

Dream Fitness

Dream Fitness have been a key partner in Armadale for the last five years and have been involved in the delivery of programmes and events aligned to physical activity. This includes the provision of the jolly joggers groups and the Run for Fun. They are now also supporting the delivery of activity sessions for T4H in Fauldhouse, including the provision of a 'run, jump, throw' classes for young people.

Fauldhouse Community Development Trust

FCDT have been the lead partner in the delivery of T4H in Fauldhouse since the inception of the programme three years ago. They have supported events and activities through providing marketing materials, helping with promotion, providing staff and volunteers and incorporating T4H into existing key events in the Fauldhouse calendar such as the Spring Fair and the Septemberfest Music Festival. FCDT are now delivering the Fauldhouse Santa Parade with minimal council input, helping to ensure this is a sustainable community event for the future.

GRC Triathlon

GRC Triathlon has been involved in delivery of events in Fauldhouse, including supporting the first Run for Fun event with the provision of local volunteers and equipment. They will lead the delivery of the 2017 event in Fauldhouse and are supporting the establishment of other Run for Fun events in West Lothian.

D5 Capacity Building

Local Community

A strategy of encouraging participation continues to underpin the project, with local parents and residents supported to develop through their involvement with T4H. An informal Jog Leader programme has developed participants who have been actively working with T4H on the weekly Jolly Joggers sessions, while the T4H Friends of the Project database has over 500 people registered for regular updates of the project's events and activities.

T4H continues to work with Community Youth Services staff to help them to promote health and wellbeing to their groups. This approach builds capacity whilst enhancing health and wellbeing at the same time. It also provides shared resources, such as staffing, to ensure that activities can take place.

The signature events of the project have attracted local support in respect of their organising and planning. This provides valuable insight into community needs and reflects how well the activities and interventions are valued.

D6 Evaluations

Customer feedback is regularly evaluated to maintain the effectiveness of T4H and its project delivery and we continue to make changes and improvements to programme delivery and content based on feedback received. However, due to reduced staffing of the project over the past 18 months, a reduced amount of data has been collected. Staff resources have been focussed on ensuring continued delivery of the key activities and interventions that the communities value, and on maintaining T4H brand recognition.

As has been highlighted throughout this report, there has been a particular focus over the past year on transferring responsibility for delivery of activities, where appropriate, to local community partners. This ensures that, in light of reducing resources in the public sector, long term sustainability of these interventions is secured. In addition to enabling these activities to continue, this also builds capacity in the community and increases the skills and confidence of the individuals and community groups involved.

E. CONCLUSION

The Together for Health project continues to provide health and wellbeing programmes and interventions aimed at reducing and preventing childhood obesity. In 2015 the project was implemented in the Fauldhouse community and is now well established within the village.

The project has successfully transferred some key events and activities to community ownership, and continues to look for future opportunities to build capacity in the T4H communities, and further afield. This is a reflection of the strength of the programme, the commitment and buy-in from the local communities, and the additional community capacity that has been developed by Together for Health throughout the life of the project.

F. BACKGROUND REFERENCES

None.

Appendices/Attachments: None

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Craig McCorriston

Head of Planning, Economic Development and Regeneration

24 August 2017

DATA LABEL: PUBLIC

West Lothian Council

HEALTH AND CARE POLICY DEVELOPMENT AND SCRUTINY PANEL

HEALTH IMPROVEMENT PRIORITIES

REPORT BY CONSULTANT IN PUBLIC HEALTH

A. PURPOSE OF REPORT

The purpose of this report is to inform the Panel about the work of the Health Improvement and Health Inequalities Alliance, its priorities for future work, and the proposed activities to be funded in the next round of Health Improvement Fund projects from April 2018.

B. RECOMMENDATION

It is recommended that the Board notes the proposed priorities.

C. SUMMARY OF IMPLICATIONS

I	**Council Values**	Focusing on our customers' needs Being honest, open and accountable Working in partnership.
II	**Policy and Legal (including Strategic Environmental Assessment, Equality Issues, Health or Risk Assessment)**	
III	**Implications for Scheme of Delegations to Officers**	None.
IV	**Impact on performance and performance Indicators**	.
V	**Relevance to Single Outcome Agreement**	The Health Improvement and Health Inequalities Alliance contributes to the following outcomes in the SOA/LOIP: We live longer, healthier lives and have reduced health inequalities. Our children have the best start in life and are ready to succeed.
VI	**Resources - (Financial, Staffing and Property)**	The resource implications include £213,268 of HIF funding, and staff time to develop and implement a revised work programme for the Alliance.

	None
VII Consideration at PDSP	
VIII Other consultations	Members of the Alliance were asked to consult with a range of colleagues and opportunistically at other meetings they attended, by asking the following three questions: 1. What are the key issues and assets that affect health in WL? 2. What are the gaps in health improvement work? 3. Which determinants should we focus on in order to make biggest difference to health? In this way, feedback was obtained from members of the Strategic Planning Group, the Whitburn Regeneration Action Group, the Early Intervention and Prevention Working Group and West Lothian Tobacco Free group. In addition, the working group drew on feedback from attendees of the Health and Social Care Partnership Localities Development day that was held in June 2016

D. TERMS OF REPORT

D1 Role of the Health Improvement and Health Inequalities Alliance

The Health Improvement and Health Inequalities Alliance (HIHIA) has been in place in its current form since 2011. Its overall aim is 'to improve the health and well-being of those who live and work in West Lothian and to address the gap between those with the best health outcomes and those with the poorest health outcomes'. It is responsible for providing strategic direction for specific areas of health improvement work, with operational delivery being the responsibility of the relevant managers. It works within the framework of the Local Outcomes Improvement Plan and other relevant strategic frameworks. Its responsibilities include oversight of West Lothian activities funded by the Health Improvement Fund.

The role of the HIHIA is defined in its terms of reference as:

- Develop a coordinated approach and vision for the delivery and
- planning of health improvement activities in West Lothian;
- Monitor the plans developed by each of the sub-groups to take forward the vision of the HIHIA;
- Ensure that progress towards achieving key outcomes is monitored and reported through the Community Planning process;
- Act as a conduit between community planning partnership and operational activity;
- Identify cross cutting issues across the sub-groups and develop integrated multi-agency solutions;
- Set up and oversee short-life working groups to address specific strands of work which will contribute to agreed Community Planning Partnership outcomes;
- Act as a key consultative group for major policy development with a strong focus on influencing strategic plans across the Community Planning Partnership;
- Develop processes which maintain a regular and effective means of communication between partnerships;
- Promote joint staff training and development.

D2 Health improvement delivery

HIHIA currently oversees action plans for the following areas of work:

- Children and Young People's health and wellbeing (also reports to the Children's Strategic Planning Group)
- Health in Later Life
- Tobacco
- Food and health (West Lothian eatright and Infant Feeding programmes)
- Physical activity (West Lothian On the Move programme)

Each of these reports formally to HIHIA at least once per year. Other sub-groups working on oral health, sexual health, and mental wellbeing are no longer meeting because the relevant programmes are being developed and delivered at a Lothian level and there is limited staff capacity to support local groups.

D3 Strategic influence

As well as overseeing programmes of work to address these health improvement topics, HIHIA recognises that wider work within the Community Planning Partnership has a significant impact on health. For this reason, the group also provides input to other policy areas as appropriate. In the last year this has included, for example, engaging with the development of the Local Development Plan, Active Travel Plan and Local Housing Strategy.

D4 Setting priorities for future work

Between January and April 2017, members of the Alliance collated evidence and data to inform the development of priorities for its future work. The work has included collating the following:

- Relevant reports about the West Lothian context
- Routine data on health and health determinants in West Lothian
- Information on current health improvement activities in West Lothian
- Consultation with members of other groups in West Lothian
- A development session involving members of the working group

Findings are summarized in the paper in Appendix 1, *Priorities for Health Improvement in West Lothian.*

D5 Priorities

Following discussion and consideration of the evidence, the group has identified the following priorities. Further information on each of these is given in the full paper in Appendix 1.

- **Family Engagement to promote mental health and wellbeing in children and young people**

  Stakeholders identified mental wellbeing for children and young people as a clear priority. It will be addressed through the work of the Early Intervention and Prevention Group, which reports through HIHIA and also through the Children's Strategic Planning Group. In addition, stakeholders identified parenting support as a priority to ensure parents are able to support their children's wellbeing. To address these linked issues, HIHIA recommends that work should be commissioned to achieve 'Improved family functioning and resilience in children and young people'.

- **Infant Feeding**

  West Lothian continues to have low rates of breastfeeding. It has completed the initial stages of UNICEF Baby Friendly in the Community accreditation and this work is led by an Infant Feeding Advisor, funded by HIF. HIHIA recommends that this work should continue but that in addition there is a need for further work to enhance community and family support for breastfeeding mothers.

- **Preventative interventions to promote healthy weight in children and young people**

  The prevention of obesity requires work to improve nutrition, reduce nutritional inequalities, and also to increase physical activity. These require partnership work as well as delivery of specific interventions and both will continue to be areas of focus for HIHIA. HIHIA recommends that work be commissioned to address nutritional inequalities and, separately, to increase physical activity. Both of these should focus on children and young people. The work on nutrition and nutritional inequalities should encompass community support for breastfeeding mothers as noted above.

- **Income maximization**

  Poverty is well recognized as a fundamental cause of poor mental and physical health. Welfare advice services can demonstrate good evidence of financial gains to people using them, which is very likely to bring wider benefits to their health. Currently welfare advice services are provided in several healthcare settings in West Lothian and there is work to agree a strategic approach to avoid duplication and ensure these are best located in relation to need.

- **Community led health**
  A recent review identified a need to increase community capacity in West Lothian by funding community led health work. In discussion, HIHIA considered that work towards the above outcomes could best be met by work that explicitly adopts a community led health approach. In addition, HIHIA will continue to explore how to encourage and support community led health approaches within West Lothian.

E. CONCLUSION

Health Improvement Fund recommendations

HIHIA was asked to provide recommendations to NHS Lothian for the next round of NHS Lothian Health Improvement Funding, from April 2018 to March 2021.

The overall priorities that were set for this funding are:

- Early years support and early interventions for children and young people
- Social capital and community capacity building.

There will be a total of £213,268 available for West Lothian projects from April 2018. The responsibility for the funding sits with the NHS Lothian HIF Oversight Group but heath improvement partnerships were asked to recommend the priority activities and outcomes for the next round of projects. Projects will be commissioned to meet the agreed outcomes with support from NHS Lothian Procurement.

Based on the above considerations, HIHIA has recommended the following investment priorities for the Health Improvement Fund in West Lothian. These are directed towards the health improvement priorities discussed above.

Outcome	Activity	Maximum allocation
Improved family functioning and resilience in children and young people	Delivery of programme of activities to meet this outcome using a community led health approach– to be commissioned	51,000
Improved infant feeding knowledge and practice	Funding of the Infant Feeding Advisor post	30,000
Improved nutrition and reduced nutritional inequalities particularly for children and young people	Delivery of programme of activities to meet this outcome, including work to increase community support for breastfeeding mothers, using a community led health approach– to be commissioned	51,000
Increased physical activity in children and young people	Delivery of programme of activities to meet this outcome using a community led health approach– to be commissioned	51,000
Income maximisation for individuals and families with low financial resources	Delivery of welfare advice service in selected GP practices – to be commissioned	30,000
TOTAL		**£213,000**

F. BACKGROUND REFERENCES

Scottish Government Health and Social Care Delivery Plan:
http://www.gov.scot/Publications/2016/12/4275

Appendices/Attachments:

APPENDIX 1: PRIORITIES FOR HEALTH IMPROVEMENT IN WEST LOTHIAN

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Date: 24th August 2017

PRIORITIES FOR HEALTH IMPROVEMENT IN WEST LOTHIAN

HEALTH IMPROVEMENT AND HEALTH INEQUALITIES ALLIANCE, APRIL 2017

INTRODUCTION

The West Lothian Health Improvement and Health Inequalities Alliance [HIHIA] is a Partnership Group that aims 'to improve the health and well-being of those who live and work in West Lothian and to address health inequalities between those with the best health outcomes and those with the poorest health outcomes'.

The role of HIHIA, as defined in its Terms of Reference, is given in Appendix 1. HIHIA currently oversees action plans for the following areas of work:

- Eatright
- West Lothian on the Move
- Tobacco
- Children and Young People's health and wellbeing (also reports to the Children's Strategic Planning Group)
- Health in Later Life

In addition, in recognition of the important impact on health of wider work within the Community Planning Partnership, the Alliance also provides input to other policy areas as appropriate.

The Alliance does not oversee work relating to drugs or alcohol, as these have been addressed by the alcohol and drugs partnership (ADP), although the ADP is currently not meeting.

HIHIA makes recommendations to NHS Lothian on the West Lothian funding identified within the NHS Lothian Health Improvement Fund (HIF). NHS Lothian is reviewing priorities for the Health Improvement fund and has asked each of the Lothian Health Improvement Partnerships to identify priorities for their area. These should reflect the overall priorities for HIF, which are:

- Early years support and early interventions for children and young people
- Social capital and community capacity building.

This report has been agreed by HIHIA members in order both to outline priorities for the future work of the Alliance, and more specifically to inform future funding priorities for HIF.

METHODS

This report summarises information drawn from a range of sources:

- Relevant reports about the West Lothian context
- Routine data on health and health determinants in West Lothian
- Consultation with members of other groups in West Lothian
- A development session involving members of the working group

Reports and data sources

The group reviewed information from available reports and data profiles including:

- West Lothian single outcome agreement
- West Lothian Community Planning Strategic Needs Assessment
- West Lothian regeneration framework
- West Lothian "Better Off" Anti Poverty Strategy
- West Lothian Ward Profiles
- West Lothian Economic Profile
- West Lothian Community health profile
- West Lothian Health and Wellbeing Profiles – key indicators and overview
- The role of the third sector in supporting community development for health – a scoping exercise in West Lothian
- Findings of Early Intervention and Prevention Needs Assessment

Consultation

The group used three questions to identify views on the priority health improvement issues in West Lothian. The questions were:

1. What are the key issues and assets that affect health in WL?
2. What are the gaps in health improvement work?
3. Which determinants should we focus on in order to make biggest difference to health?

HIHIA members considered these questions themselves at a HIHIA meeting in December 2016 and then members of the Alliance were asked to use them opportunistically at other meetings they attended. In this way, feedback was obtained from members of the West Lothian Strategic Planning Group, the Whitburn Regeneration Action Group, the Early Intervention and Prevention Working Group and West Lothian Tobacco Free group. In addition, the working group drew on feedback from attendees of a Health and Social Care Partnership Localities Development day that was held in June 2016.

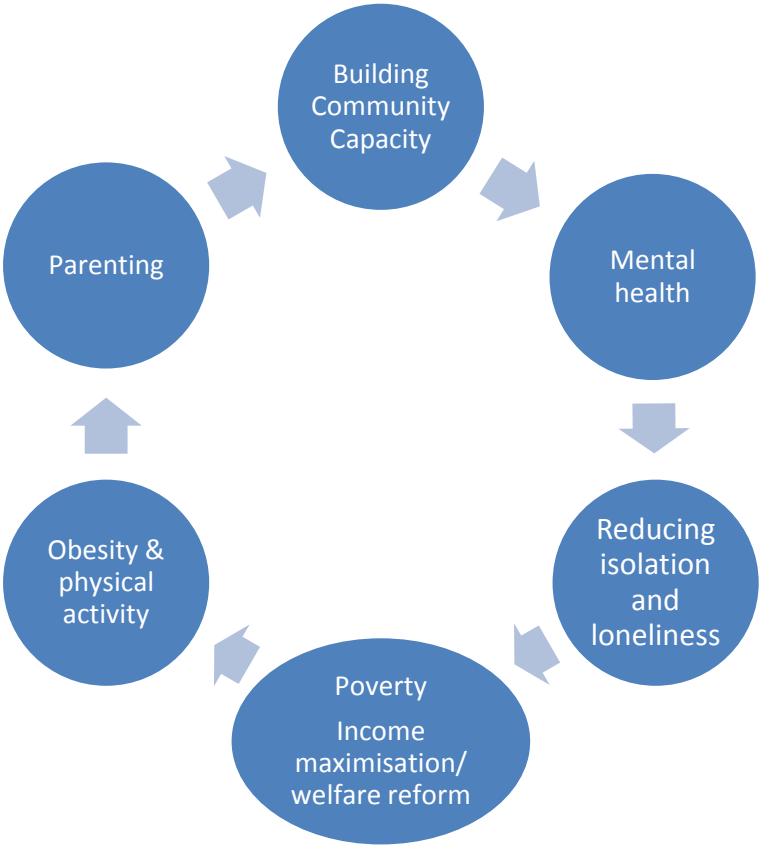
Identifying priorities

The working group held a development session in February 2017. The group reviewed available feedback and considered:

- Our evidence base and what it tells us about the health and wellbeing of the people of West Lothian.
- What works/strengths/assets we can build on/enhance with in West Lothian?

- Gaps/deficits in West Lothian and how do we know?
- Specific groups who may require extra support to achieve better health outcomes.

This generated a list of potential priorities for future health improvement activity, which were refined then circulated to all HIHIA members for further comment. The potential priorities are shown in the diagram below. It is worth noting that development session participants felt that the areas of priority are inter-linked.



These priorities and the other evidence here were then considered at a HIHIA meeting in March 2017 to agree the priority outcomes outlined at the end of this report.

THE WEST LOTHIAN CONTEXT

The population, environment and economy of West Lothian have been changing rapidly in recent years.

The total population of West Lothian has been increasing steadily and was estimated to be 178,550 in 2015. Currently West Lothian has the youngest population in Scotland, but this means that it is now aging more rapidly than most areas of Scotland. It is estimated that between 2012 and 2037 there will be:

- 89.9% increase in the over 65 population in West Lothian.
- 140.2% increase in the over 75 population.
- A decrease in the working age population in West Lothian. The 25-49 age group will decrease by 3.6% while the 50-64 age group will decrease by 8.3%.

In the East of West Lothian, over 50,000 people live in the new town of Livingston. In the West many settlements are former coal mining towns with strong community identities. Recent house building has brought new residents to many of these towns. There are also smaller rural villages and two thirds of the land is agricultural. About 44% of workers living in West Lothian commute out of the area to work and 64% of adults commute to work by car.

In 2014, 67% of West Lothian households were owner occupied compared with 60% in Scotland overall. The social rented sector was 22% compared with 24% for Scotland. The private rented sector has been increasing across Scotland and in West Lothian increased from 1% of households in 1999 to 10% in 2014, though this is still less than the Scottish average of 14% in that year.

The number of households in West Lothian is projected to increase from 73,847 in 2012 to 84,500 in 2037, an increase of 17%. West Lothian already has a high proportion of households with children and this is projected to continue. The proportion of single person households in West Lothian is below the Scotland average but is projected to be more than a third of all households by 2037. This may imply a large number of people at risk of social isolation.

West Lothian is less affluent than many other parts of Lothian and has a higher proportion of people living in the 20% most deprived areas in Scotland. The average gross annual salary for jobs located in West Lothian is slightly lower than the Scottish average, although this gap has been narrowing. The Local Regeneration Framework seeks to target resources to the communities with the highest needs, while recognising the need for broader action as about half of the people with high levels of need live outside these areas. Better Off, the West Lothian Anti-Poverty strategy, aims to minimise the impact of poverty across West Lothian, particularly given the impact of recent recession and welfare reform. These strategies are important for health because the health of the West Lothian population closely reflects the social and economic circumstances of residents.

HEALTH IN WEST LOTHIAN

Life expectancy has increased steadily in the last ten years in West Lothian. In 2013, life expectancy in West Lothian was 77 years for males and 80 years for females. This is the lowest life expectancy in Lothian for both sexes and below the Scotland average life expectancy for females.

The West Lothian Health and Wellbeing profile identifies the following indicators for which West Lothian differs significantly from the Scotland average, to suggest possible priorities for improvement:

- Active travel to work – 10% in West Lothian compared with 16% in Scotland.
- Babies exclusively breastfed at 6–8 weeks - 24%, compared with 27% in Scotland.
- Mothers smoking in pregnancy – 22%, compared with 19% in Scotland.
- Psychiatric hospitalisation – 341 per 100,000 people compared with 292 per 100,000 in Scotland.
- Young people not in employment, education or training – 8% compared with 7% for Scotland.
- Older people (65+) with multiple emergency hospitalisations – 5,945 per 100,000 people, compared with 5,159 per 100,000 for Scotland.

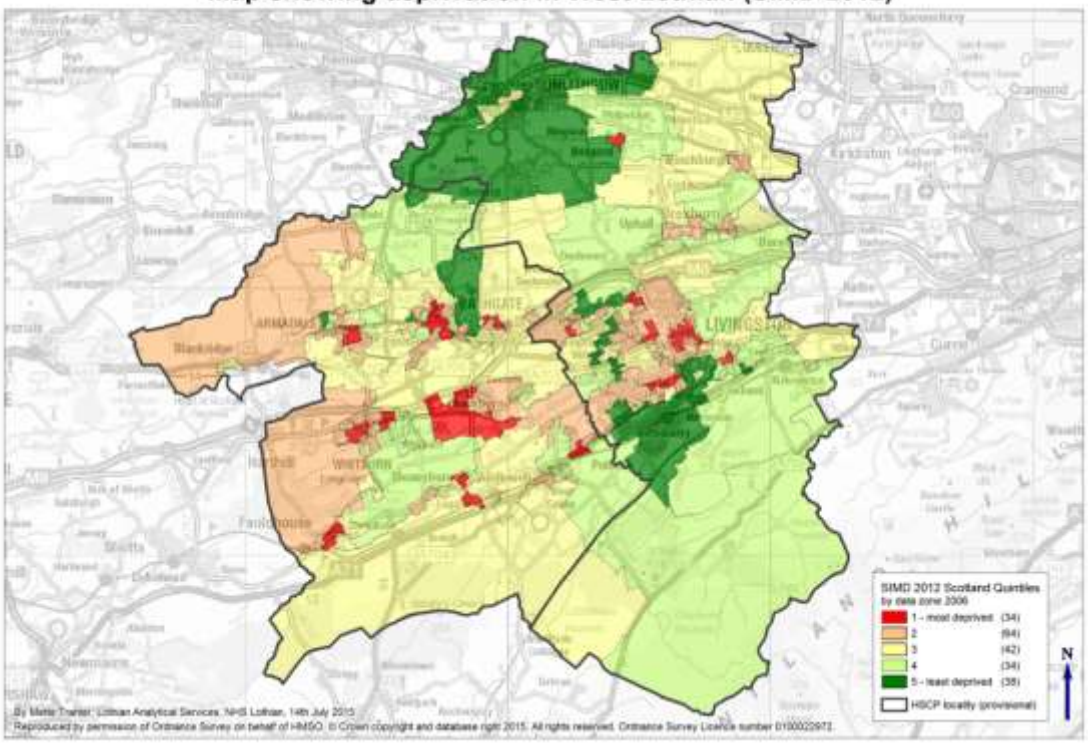
Inequalities

There are differences in life expectancy which reflect wider inequalities across the area. Life expectancy is 74.1 years for men living in the 20% most deprived areas in West Lothian but 80.4 years for men living in the 20% least deprived areas in West Lothian. The equivalent figures for women are 78.5 years and 82.7 years. For nearly all health indicators there is a gradient showing better health with increased affluence.

Mortality rates until recently were significantly higher in the West locality of West Lothian, but the rates have been converging. This may reflect differences in population as newer populations move into communities that have previously experienced poor relatively poor health.

Health inequalities reflect social circumstances and the underlying distribution of power and resources in the population. To address 'health' inequalities it is as important to tackle major non-medical causes of ill health, like social isolation, homelessness and poverty as it is to tackle individual behaviours and clinical risk factors. This means that making links between health outcomes and work in diverse policy areas such as planning, housing, education, transport, employability, sport and leisure is important to improve health of the people most likely to suffer poor health.

Map showing deprivation in West Lothian (SIMD 2012)



CURRENT HEALTH IMPROVEMENT ACTIVITY IN WEST LOTHIAN

West Lothian has an aging population and this will increase future demands on health and social care services, which are already recognised to be under pressure. This reinforces the need to invest in interventions that can promote positive wellbeing and prevent future ill health.

The working group attempted to map the current activity in West Lothian that is 'badged' as health improvement and specifically funded as such. In doing so, the group recognised that a wide range of activities and services can have a positive impact on health and it can be difficult to define and separate out 'health improvement' activity.

There are several clinical services that work with individuals to address and prevent risk factors for future disease rather than (or as well as) treating current illness. These include, among others, smoking cessation, immunisation, provision of contraception, routine dental care, child and adult weight management, antenatal care, health visiting services. These preventative services are very important and should be supported, but a full mapping of these is beyond the scope of this report.

Other mainstream public services such as education, early years services, social work, criminal justice, community learning and development, housing and leisure are all important to promote good health and prevent ill health. The previous section identified the contextual issues that affect health of people in West Lothian. As noted, as well as delivering specific interventions and programmes it is important to work with other policy areas to try to ensure that wherever possible the physical, social and economic environments all promote good health.

The third sector can also play an important role in health improvement. There are approximately 600 groups and organisations within the third sector in West Lothian. The strength of the third sector is their flexibility to be able to react to the changing needs of the communities they work with. They often have strong links and relationships with local people and staff work hard to foster good relationships which allow them to be seen as part of the community. A scoping review of community led health in West Lothian found relatively few organisations that considered their work to be focused on health improvement. But although third sector organisations might not define their work explicitly as health improvement, they often support health and well being by connecting people and building community capacity. Given current pressures on the public sector, more joined up working between the third sector and public sector can be a way to support local communities to take control of and improve their own health.

The table shows only activities that are 'badged' as health improvement in West Lothian. Activities that are not funded beyond April 2017 have been excluded from this table. Most, but not all, of these activities fit the definition of health improvement below which is used for HIF funded projects:

"The main function of health improvement is to find ways of preventing ill-health, protecting good health and promoting better health – this is closely linked to quality of life and the concept of well being. This is achieved by working with local communities and organisations across public, private and voluntary sectors to address the personal, socio-economic and cultural factors that influence the health of each person. Relevant interventions are at the level of group, (inter) organisation, community, whole population and systems. This should be distinguished from clinical interventions that treat individual patients".

Table: 'Badged' health improvement activities and services in West Lothian, 2017

	Activity	**Funding source**
	Health Improvement Team Manager	WLC/IJB
Community led health	Health Issues in the Community programme	WLC/ IJB
Food and health	Food & health development officer	NHS Lothian - HIF
	'Get Cooking' programme	WLC/ IJB
	School Food programme	NHS Lothian - HIF
Physical activity	WL On the Move development officer	NHS Lothian - HIF
	Put Your West Foot Forward programme	NHS Lothian - HIF
	Buddy walks programme	NHS Lothian - HIF
	Ageing Well programme	NHS Lothian
Mental health	Mental Wellbeing Development Officer	WLC/IJB
Child health	Children and Young People team	WLC
	Child Safety equipment	NHS Lothian - HIF
	Infant Feeding programme	HIF/ NHS Lothian
	Sure Start	WLC
Tobacco	WLDAS Young People and tobacco programme	NHS Lothian
Income maximisation	CAB service in 5 General Practices	NHS Lothian - HIF
Generic (current focus on child health)	Senior Health Promotion Specialist	NHS Lothian

(As noted above, the table does not include clinical preventative services or services relating to drugs or alcohol.)

The table shows that there are several different sources of funding for these activities. NHS Lothian is currently reviewing priorities for HIF funding and has asked HIHIA to make recommendations regarding the activities to fund using HIF in West Lothian. The recommendations need to take account of the impact of ceasing any of the current HIF funded activity, and ensure HIF funded activity complements but does not duplicate activities that are funded from other sources.

In addition to these activities, which are all specific to West Lothian, there are several NHS Lothian Senior Health Promotion Specialists, each of whom works across Lothian on a specialist topic. Among others, they deliver programmes for: Food and Health; Physical Activity; Sexual Health; Children and Young People; Tobacco prevention; Prison Health; Capacity building programme and others.

PRIORITIES FOR FUTURE HEALTH IMPROVEMENT ACTIVITY IN WEST LOTHIAN

The group developed the priorities detailed below based on consultation feedback and taking into account the other evidence detailed in this document. This section outlines very briefly why the group identified each of these as a priority, suggests some of the kinds of interventions needed to address them, and specifies recommended outcomes to be sought from the interventions to be funded from HIF. In each case, the specific interventions funded by HIF need to be part of an overall programme of work involving other partners to make a broader impact.

Family Engagement

There is growing evidence that childhood experiences – positive or negative – have long lasting effects on both physical and mental health throughout life. The consultations highlighted particular concern about young people's mental health and wellbeing in West Lothian, with significant pressures on mental health services for young people. Poor mental health among children and young people can also have long term impacts on their educational attainment, health related behaviours, economic and health outcomes throughout their lives.

Mental wellbeing, for both children and adults, is promoted by positive factors including positive and supportive social connections, adequate sleep, exposure to greenspace, and physical activity. Stressors that can damage mental wellbeing include social and economic exclusion, trauma, poor environmental conditions. Children's physical and mental health are strongly affected by family relationships, parental health, household adversity, and the availability and quality of support to parents/carers.

Societal and community level actions are needed to address many of these issues, and this requires wider partnership work. The group recognised support for parents/carers as a priority to underpin healthy attachments and provide parents/carers with skills that foster positive mental and physical health. There was concern not to duplicate other programmes including those delivered by the Children and Young People team in Social Policy.

Outcome: Improved family functioning and resilience in children and young people.

Activity to fund: Delivery of a commissioned programme of activities to meet this outcome using a community led approach for parents/carers to foster healthy attachments, good relationships, home activities, play and respectful communication in families from an early stage.

Infant Feeding

There is ample evidence of the benefits of breastfeeding to both the baby and the mother. The group felt this should continue to be a priority area because West Lothian's breastfeeding rate remains stubbornly low compared to the Scottish average, and there are evidence-based interventions, which are being implemented but need continued support to have an impact. There is also growing awareness of the importance of optimal maternal nutrition, with particular concern about maternal obesity.

Breastfeeding is influenced by the quality of support available to mothers, practical issues such as return to work and workplace policies, the attitudes of their partners and other family members, wider cultural attitudes and marketing activities of formula manufacturers. A long term programme

of work is needed at national and local levels to address all of these issues. There is a national programme to improve Maternal and Infant Nutrition, which in West Lothian is led by an Infant Feeding Adviser funded by HIF. This work programme has been focusing on obtaining UNICEF Baby Friendly Accreditation, which was achieved during 2016.

The group felt it is important to maintain the existing work to ensure high quality professional and peer support for women and to strengthen this by identifying ways to engage with relatives and partners. There was a suggestion the current post should be funded by mainstream NHS funding rather than HIF.

Outcome: Improved infant feeding knowledge and practice.

Activity to fund: Continued provision of an infant feeding advisor post in West Lothian

Preventative interventions to promote healthy weight

The consultations highlighted concern about the rising prevalence of obesity in West Lothian. Obesity is associated with an increased risk of a range of health conditions and increased mortality. It is now well recognised that the causes of the increase in obesity relate to an 'obesogenic environment'. Features of the obesogenic environment include car dominant modes of transport with reduced daily physical activity and over-supply and marketing of foods that are high in calories but often low in other nutrients.

The prevention of obesity needs to include both actions that increase levels of physical activity and actions that support healthier nutrition. There are of course many other health benefits from increased physical activity and better nutrition.

Physical activity brings numerous benefits to physical and mental health. The greatest benefits are experienced by people who were previously inactive. A recent Scottish review identifies three priority interventions to increase population physical activity: 'Whole-of-school' programmes, advice on physical activity within healthcare; transport systems that prioritise active travel. In West Lothian the On the Move programme is funded by HIF and includes a development officer, and officers who coordinate the Keep Your West Foot Forward programme of walking groups and Buddy Walks. They also work closely with the Active Travel coordinator.

An adequate, balanced diet is a necessity for good health. Many people in Scotland eat a diet that is low in fruit and vegetables but rich in high-energy processed foods. Nutritional inequalities contribute to health inequalities – not least because the cost of eating a healthy diet is greater than the cost of eating a less healthy diet. Food poverty and food insecurity are increasing, with adverse effects on health. Food consumption is driven by food production and marketing as much as individual choices. At national level there is work with food industry seeking to formulate healthier products. In West Lothian the eatright programme is funded by HIF and includes the eatright development officer and a school food development officer.

Outcome 1: Improved nutrition and reduced nutritional inequalities particularly for children and young people.

Activity to fund: Delivery of a commissioned programme of activities to meet this outcome, including work to increase community support for breastfeeding mothers, reduce maternal obesity and support good family nutrition using a community led health approach.

Outcome 2: Increase physical activity in children and young people.

Activity to fund: Delivery of a commissioned programme of activities to meet this outcome using a community led health approach.

Income maximisation

The group recognised this as a priority because of the very strong links between poverty and poor health. West Lothian has several areas with relatively high numbers of people with low incomes. Much of the actions to address that sit within the Anti-Poverty Strategy and in Regeneration Plans. It is important that any other activities supported by HIHIA complement these.

There is growing evidence of the benefits of co-locating welfare advice services in healthcare settings. This is less stigmatising, enables the services to reach people in need, and can reduce some of the pressures on general practices. In West Lothian five general practice locations have co-located advice sessions, funded by HIF. The service can demonstrate high financial returns for the patients who use them. A needs assessment of welfare advice in NHS settings has identified priority locations to deliver these services, recognising the need for a strategic approach to make the best use of all advice services across West Lothian. A report outlining this approach is being developed to go to both the Anti-Poverty Strategy and the IJB.

The group recommended that this service should continue to be supported by HIF and that HIHIA should work closely with the Anti-Poverty Strategy to ensure it complements other services and targets the practices with high levels of need. There was however a suggestion that some of this may be delivered by re-locating some of the mainstream work of advice providers.

Outcome: Income maximisation for individuals and families with low financial resources..

Activity to fund: Delivery of commissioned Welfare Advice Services in selected general practice locations.

Social capital and reduced isolation

In West Lothian the projected increase in single person households, influxes of new populations into existing communities and pressures on public servcies all suggest that developing community capacity and social capital should be a priority.

Research studies consistently support a strong association between social capital and both mental and physical health. Communities with high level of social participation and cohesion have higher individual and collective resilience as well as general wellbeing. This can be supported by community led health activities, which are designed to foster strong local ownership. These activities use a community development approach to engage with local people, and other agencies, and increase the capacity of the community to respond to their own issues and priorities.

In West Lothian for many years there has been Health Issues in the Community training for community activists. There are over 600 voluntary sector organisations although few of these identify themselves as having a specific health improvement role. The group identified a need to increase community capacity in West Lothian and agreed that several of the priorities above should be delivered using a community led health approach. This was felt more appropriate than providing more generic funding for community led health. The group also recognised the important role of the Voluntary Sector Gateway to support this approach more widely.

Appendix 1: **Role of the Health Improvement and Health Inequalities Alliance**

The role of the HIHIA is to:

- Develop a coordinated approach and vision for the delivery and planning of health improvement activities in West Lothian;
- Monitor the plans developed by each of the sub-groups to take forward the vision of the HIHIA;
- Ensure that progress towards achieving key outcomes is monitored and reported through the Community Planning process;
- Act as a conduit between community planning partnership and operational activity;
- Identify cross cutting issues across the sub-groups and develop integrated multi-agency solutions;
- Set up and oversee short-life working groups to address specific strands of work which will contribute to agreed Community Planning Partnership outcomes;
- Act as a key consultative group for major policy development with a strong focus on influencing strategic plans across the Community Planning Partnership;
- Develop processes which maintain a regular and effective means of communication between partnerships;
- Promote joint staff training and development.

West Lothian Council

HEALTH AND CARE POLICY DEVELOPMENT AND SCRUTINY PANEL

EUROPEAN FOUNDATION FOR QUALITY MANAGEMENT (EFQM) LEVELS OF EXCELLENCE PROGRAMME

REPORT BY DEPUTE CHIEF EXECUTIVE

A. PURPOSE OF REPORT

This report provides an outline of the process the partnership followed for European Foundation for Quality Management (EFQM) Recognised for Excellence programme.

B. RECOMMENDATION

It is recommended that the Health and Care PSSP note the process followed for the EFQM process in 2016/17.

C. SUMMARY OF IMPLICATIONS

I	**Council Values**	• Focusing on our customers' needs • Being honest, open and accountable • Providing equality of opportunities • Making best use of our resources • Working in partnership
II	**Policy and Legal (including Strategic Environmental Assessment, Equality Issues, Health or Risk Assessment)**	None
III	**Implications for Scheme of Delegations to Officers**	None
IV	**Impact on performance and performance Indicators**	Supports key partnership outcomes and priorities and service indicators
V	**Relevance to Single Outcome Agreement**	Performance against the health and well being indicators within the Single Outcome Agreement is evidenced as 'key results' and a fundamental part of the assessment process.
VI	**Resources - (Financial, Staffing and Property)**	The cost of the process is dependent on the scale of the assessment and has been estimated at £7,400
VII	**Consideration at PDSP**	None

VIII Other consultations None

D. TERMS OF REPORT

Recognised for Excellence and Scottish Awards for Business Excellence 2017

EFQM Levels of Excellence

EFQM Levels of Excellence is a recognition programme that is used by organisations, alongside internal assessment, to monitor and validate their progress through external validation and to compare their practice with sectors across Europe, including 'best in class' high performing organisations.

The partnership submitted an application to the Recognised for Excellence programme 2017 – which is the top tier of Levels of Excellence. There are three levels within Recognised for Excellence (R4E) and these are determined by externally assessed scores:

- 5 Star (500 – 600 points)
- 4 Star (400 – 500 points)
- 3 Star (300 – 400 points)

The basic requirements of the Recognised for Excellence (R4E) process were that the partnership made a submission by 9th December 2016, and then accommodated a five-day site visit by an external team of EFQM assessors in the week commencing 20th March 2017.

There are three main phases to the assessment process and these are summarised in sections D.2 to D.4 below of this report.

D2 Phase 1: Submission writing and evidence gathering

The organisation prepared a submission against the nine criteria of the EFQM Excellence model. The submission document contains three sections and is a maximum of 30 pages plus organisational chart and glossary of terms used:

- **Section 1 - Key information**
  Presents the key facts about the organisation which helps assessors to gain an overall view and to understand key strategies.

- **Section 2 - Enabler map**
  Gives the assessor team an overview of approaches and how these "map" or fit to the enabler criteria of the EFQM Excellence model.

- **Section 3 - Results**
  The most significant (relevant to the organisation's strategic direction) results for each of the results criterion parts of the EFQM Excellence Model.

D3 Phase 2: Site Visit

The site visit provided the secondary evidence in the assessment process. The assessors used a combination of testimony gathered through interviews and focus groups, and observation of practice to assess and confirm the partnership evidence in the submission.

The site visit involved the following:

- Interviews with:
  - Senior /Extended Management Team
  - Service managers
  - Subject specialists
- Representative focus groups with:
  - Managers
  - Employees
  - Key patient/service users focus groups
- Visits to services
  A number of service managers were also interviewed about their role as process leads. As in any assessment it was important that assessors were given a consistent and positive view of the partnership, where the strengths are, the challenges faced by the partnership, and how it is changing and continuously improving.

D4 Phase 3: Feedback

The partnership was delighted to receive Recognised for Excellence 3 star at The Scottish Awards for Business Excellence 2017 on 21st June in Glasgow, attended by over 300 guests from the private, public and third sector who celebrated outstanding achievement in the field of business excellence.

A detailed 50 page feedback report was also received and a feedback meeting with the Lead Assessor arranged for late August.

The R4E assessment feedback report will allow the partnership to focus on areas that are in need of further development. This in combination with the possibilities of integration will enable the partnership to push the boundaries and seek to further transform health and social care services.

E. CONCLUSION

To date, West Lothian is the only Health and Social Care Partnership in Scotland to participate in the Quality Scotland Business Excellence awards process. Achieving Recognised for Excellence, the third level of award confirms West Lothian has set the standard as sector leading, paving the way for other partnerships in Scotland to follow.

F. BACKGROUND REFERENCES

EFQM(European Foundation for Quality Management) Business excellence model 2013

Appendices/Attachments:	None
Contact Person:	Lesley Aitken Acting Quality Improvement Manager Lesley.aitken2@nhslothian.scot.nhs.uk
CMT Member:	Jim Forrest, Depute Chief Executive
Date of meeting:	24th August 2017

West Lothian Council

HEALTH AND CARE POLICY DEVELOPMENT AND SCRUTINY PANEL

AUDIT SCOTLAND REPORT - SOCIAL WORK IN SCOTLAND

REPORT BY HEAD OF SOCIAL POLICY

A. PURPOSE OF REPORT

The purpose of this report is to advise Panel Members on the West Lothian position with regards to the recommendations resulting from the Audit Scotland report on the national audit of social work published in September 2016.

B. RECOMMENDATION

It is recommended that the Panel notes the recommendations made by Audit Scotland and the West Lothian position.

C. SUMMARY OF IMPLICATIONS

I	**Council Values**	Focusing on our customers' needs Being honest, open and accountable Working in partnership.
II	**Policy and Legal (including Strategic Environmental Assessment, Equality Issues, Health or Risk Assessment)**	The report references the key legislative and policy drivers for social work and social care services in Scotland.
III	**Implications for Scheme of Delegations to Officers**	None.
IV	**Impact on performance and performance Indicators**	Working in partnership.
V	**Relevance to Single Outcome Agreement**	People most at risk are protected and supported to achieve improved life chances Older people are able to live independently in the community with an improved quality of life We live longer, healthier lives and have reduced health inequalities
VI	**Resources - (Financial, Staffing and Property)**	None.
VII	**Consideration at PDSP**	None

VIII Other consultations Considered by the West Lothian Integration Joint Board on 27th June 2017.

D. TERMS OF REPORT

As reported to the Integration Joint Board Audit and Risk Committee on 6th January 2017 the audit was carried out to examine how effectively councils are planning to address financial and demographic pressures facing social work in Scotland. In particular to determine the extent of the financial and demographic pressures, the strategies councils are utilising to address the pressures, the effectiveness of current governance arrangements and how councils are involving service users and carers in service planning.

The report found a number of key challenges:

- Council budgets have fallen by 11% in real terms since 2010/11. Whilst social work budgets have increased slightly since 2010/11, this is not sufficient to meet increased demand. Audit Scotland has estimated that spending will require to increase by around 16- 21% to 2020 to meet demand should councils and Integration Joint Boards (IJBs) continue to provide services in the same way.

- Current models of social work and social care are not sustainable. Fundamental decisions need to be made nationally and locally about new delivery models. Attention needs to be given to increasing community capacity.

- Whilst the integration of health and social care has made governance arrangements more complex, councils retain responsibility in relation to statutory social work services.

- With integration and other policy and legislative changes, the role of the Chief Social Work Officer (CSWO) has become more complex and challenging. CSWOs need to have the status and capacity to fulfil statutory duties effectively.

Recommendations

The report made a range of recommendations that covered the following areas:

- Social work strategy and service planning – transformative change in how services are delivered and funded is required.

- Governance and scrutiny arrangements – there should be in place robust governance arrangements that can measure and report on the efficiency and effectiveness of service delivery.

- Workforce – there should be a national, coordinated approach to addressing workforce issues.

- Service efficiency and effectiveness – to take a robust approach to disinvestment and to undertake a review of national eligibility criteria.

West Lothian position - summary

Whilst West Lothian is significantly affected by financial and demographic challenges, the council benefits from its long-term financial management strategy. The West Lothian IJB has adopted a robust strategic commissioning approach which

incorporates a number of key service redesign programmes aimed at transforming the way we deliver services across whole systems and is developing new approaches aimed at increasing community capacity.

It should also be note that the role of the CSWO is well defined and supported in West Lothian, and is linked effectively into council and partnership governance arrangements

A more detailed overview of the West Lothian position with regards to the recommendations made in the report by Audit Scotland is provided in Appendix 1.

E. CONCLUSION

The Audit Scotland Report – Social Work in Scotland highlighted the need for transformative measures to be developed and implemented to address the challenges and complexities that lie ahead for social work and social care in Scotland and it is acknowledged that the recommendations are extremely challenging to achieve both locally and nationally.

F. BACKGROUND REFERENCES

None

Appendices/Attachments:

Appendix 1: Overview of Recommendations and West Lothian Position

Appendix 2: Social Work in Scotland, Audit Scotland, September 2016

Contact Person: Jane Kellock,
Head of Social Policy/Chief Social Work Officer
jane.kellock@westlothian.gov.uk

Tel 01506 281920

Date: 24th August 2017

Appendix 1

Key Recommendations	West Lothian Position
Social Work Strategy and Service Planning.	
That transformative change in how services are delivered and funded is required. Debate to be undertaken with communities about the long-term future for social work and social care in their area to meet statutory responsibilities, given the funding available and the future challenges. Work with national and local stakeholders to review how to provide social work services for the future and future funding arrangements Develop long-term strategies for the services funded by social work by: ○ carrying out a detailed analysis of demographic change and the contribution preventative approaches can make to reduce demand for services ○ developing long-term financial and workforce plans ○ working with people who use services, carers and service providers to design and provide services around the needs	In West Lothian a comprehensive review of all health, social and economic data which is relevant to integrated planning and subsequent delivery of services designed to target those most in need has been undertaken. Strategic Needs Assessments, across all client groups have been undertaken to inform service development and planning to meet future needs. Commissioning Plans are in place for: • Learning Disability • Physical Disability • Older People • Mental Health • Children • Criminal Justice • Alcohol and Drug Partnership Commissioning Plans for both Children's Services and Community Justice Services will be developed later in 2017 following the completion of the Strategic Needs Assessments currently underway for: • Early Intervention and Prevention • Looked After Children and Young People • Community Justice

of individuals ○ working more closely with local communities to build their capacity so they can better support local people who may be at risk of needing to use services ○ considering examples of innovative practice from across Scotland and beyond ○ working with the NHS and Scottish Government to review how to better synchronise partners' budget-setting arrangements to support these strategies	A robust strategic commissioning approach has been adopted which incorporates a number of key service redesign programmes aimed at transforming the way we deliver services across whole systems, including: • **Frail Elderly Programme** - whole system approach to the most efficient and effective delivery of provision to the frail elderly population, supporting the national health and care outcomes • **Mental Health Re-design Programme** - Whole system redesign to deliver sustainable and cost effective service which meets the needs of adults with mental health problems in the community. • **Learning Disability Modernisation Programme** - Whole system redesign to shift the balance of care in favour of community based Service. The programme aims to improve wellbeing, choice, independence and inclusion for people with a learning disability **Integrated business and financial planning** The IJB has a 3 year financial planning process which is linked to strategic performance priorities. SP has an annual budget plan which is closely aligned to service priorities. Strategic Commissioning plays a key role in assessing and forecasting needs and linking investment to agreed outcomes when planning the nature, range and quality of future services. The financial plan is reviewed annually, with revenue budget set each year. This is monitored through financial controls and the budget monitoring process, with regular reports to SMT, EMT and IJB. **Participation and Engagement** The Participation and Engagement Strategy is currently in development and sets out the HSCP's commitment to involving carers and service users in developing and improving services.

Governance and scrutiny arrangements	
Ensure that the governance and scrutiny of social work services are appropriate and comprehensive across the whole of social work services, and review these arrangements regularly as partnerships develop and services change.	A clear governance framework exists within the Health and Social Care Partnership within which professionals and the wider workforce operate. Where groups of staff require professional leadership, this is provided by the relevant Health Lead or Chief Social Work Officer, as appropriate. Further assurance is provided through the responsibility of the Chief Social Work Officer to report directly to the Council and the responsibility of the Health Leads to report directly to the Medical Director and Nurse Director who in turn report to the NHS Board on professional matters. **Health and Care Governance Group** The role of the Health and Care Governance Group is to consider matters relating to the IJB strategic plan development, governance, risk management, service user feedback and complaints, care standards, education, learning, continuous improvement and inspection activity. The Health and Care Governance Group provides advice to the IJB strategic planning and locality planning groups within the Partnership. The Integration Joint Board Strategic Plan 2016-19 is currently subject to its first annual review.
Improve accountability by having processes in place to: ○ measure the outcomes of services, for example in criminal justice services, and their success rates in supporting individuals' efforts to desist from offending through their social inclusion ○ monitor the efficiency and effectiveness of services ○ allow elected members to assure themselves that the quality of social work services is being maintained and that councils are managing risks effectively ○ measure people's satisfaction with those	**Improvement** WL HSCP has a cyclical corporate programme of self-assessment to evaluate achievement in services and support improvement across the organisation. The HSCP uses the Public Service Improvement Framework which is a recognised programme of self-assessment. **Performance** A core suite of indicators have been developed from national data sources so that the measurement approach for the agreed integration health and wellbeing outcomes is consistent across all areas. The core indicators are grouped into two types of complementary measures: • Personal outcomes and quality measures and • Indicators derived from organisational/system data.

services ○ report the findings to elected members and the IJB	WL IJB has adopted a balanced scorecard approach to provide the framework for their strategic measurement and management system. The scorecard will measure organisational performance across four balanced perspectives: • **Financial & Business:** Effective resource use • **Customer:** Positive experiences and outcomes; carers are supported • **Internal Processes:** Healthier Living; Independent • **Living;** Services are safe • **Learning and Growth:** Engaged and developed workforce
Demonstrate clear access for, and reporting to, the council by the CSWO, in line with guidance. Ensure the CSWO has sufficient time and authority to enable them to fulfil the role effectively. Ensure that CSWO annual reports provide an annual summary of the performance of the social work service, highlighting achievements and weaker areas of service	The role of the Chief Social Work Officer (CSWO) is well defined and supported in West Lothian, and is linked effectively into council and partnership governance arrangements. **Governance and Access** CSWO is one of the Statutory Officers identified within West Lothian Council's Scheme of Delegation. The Scheme of Delegation also details the responsibilities of the Chief Executive of West Lothian Council to: • to meet regularly with CSWO to promote and enforce good governance, to facilitate the council's compliance with legislation and to consider and recommend to the council improvements in the corporate governance of the council where necessary; and • to ensure that the CSWO has appropriate access to elected members and senior and other officers to enable them to carry out their statutory roles effectively. Appendix 3 of the Scheme of Delegation outlines the role of the CSWO. **Reporting** The CSWO's annual report provides a summary of performance across all Social Work services, highlights developments that have been made, identifies the challenges faced by the service and outlines the action that should be taken to mitigate these challenges.

delivery, setting out the council's response and plans to improve weaker areas and that these are actively scrutinised by elected members	The report is submitted to the Social Policy PDSP, Integration Joint Board, Health and Care PDSP and to the Scottish Government annually. Work is currently underway to develop the CSWO Annual Report for 2016/17 prior to its submission to the Scottish Government by 30th September.
Workforce	
Put in place a coordinated approach to resolve workforce issues in social care	The People Strategy has been developed to support delivery of the council's priorities (Corporate Plan) and the modernisation of services. NHSL ensure effective management and development of people through robust HR strategies, policies and procedures which are aligned to the strategic direction of the organisation. The strategy and WLC/ NHSL HR policies and procedures are communicated through team briefings and meetings and intranet (mytoolkit.net and HR on-line NHSL intranet site). WL HSCP has clearly defined policies and procedures in place to ensure the organisational structure is agile and is developed to meet priorities. The structure and resources are reviewed annually through management planning. A review of our capabilities and to maximise the opportunities of integration resulted in the development of an Organisational Development and Workforce Plan 2016-2019
As part contract monitoring arrangements, ensure that providers who use zero hours contracts allow staff to accept or turn down work without being penalised.	A robust Contract Monitoring Framework is in place.
Service efficiency and effectiveness	
Include evaluation criteria and extend or halt initiatives depending on the success of new approaches in improving outcomes and value for money.	Priority setting and decision making across the HSCP is intelligence-led. Capture of customer, systems, and performance and consultation data is commissioned by leaders to inform decision making. This is evidenced through management and performance reports.
Work with COSLA to review the eligibility framework to	In conjunction with partners and key stakeholders a review of the eligibility framework will be

ensure that it is still fit for purpose in the light of recent policy and legislative changes.	undertaken to ensure that it is still fit for purpose.
Benchmark services against those provided by other councils and providers within the UK and overseas to encourage innovation and improve services	West Lothian Health and Social Care Partnership (WL HSCP) participates in professional networks and benchmarking clubs to ensure practice and performance are challenged and that we learn from best in class. WL HSCP is involved in the LGBF network and emergent family groups. Relative value of benchmarking and comparative data is challenged through internal analysis and the results are reported along with performance results, to the appropriate performance meetings and governance bodies.

Health and social care series

Social work in Scotland

ACCOUNTS COMMISSION

Prepared by Audit Scotland
September 2016

The Accounts Commission

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

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

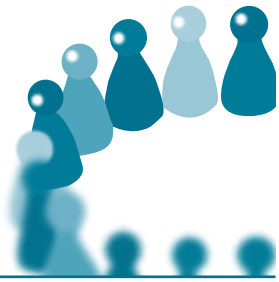
Our work includes:

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

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

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

Contents



These quote mark icons appear throughout this report and represent quotes from interested parties.

Links

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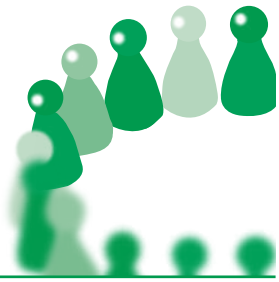
Key facts



Estimated annual value of the contribution of 788,000 unpaid carers

£10.8 billion

17,400 children are looked after or are on the child protection register

Councils spend £3.1 billion on social work services a year

£3.1 billion

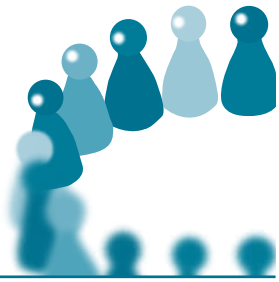
36,000 adults are in care homes and 61,500 people receive homecare

Councils spend £1.6 billion a year on social work services purchased from the third and private sectors

£1.6 billion

200,000 people are employed in social work/care, including 10,000 professional social workers

Summary



Key messages

1 Current approaches to delivering social work services will not be sustainable in the long term. There are risks that reducing costs further could affect the quality of services. Councils and Integration Joint Boards (IJBs) need to work with the Scottish Government, which sets the overall strategy for social work across Scotland, to make fundamental decisions about how they provide services in the future. They need to work more closely with service providers, people who use social work services and carers to commission services in a way that makes best use of the resources and expertise available locally. They also need to build communities' capacity to better support vulnerable local people to live independently in their own homes and communities.

2 Councils' social work departments are facing significant challenges because of a combination of financial pressures caused by a real-terms reduction in overall council spending, demographic change, and the cost of implementing new legislation and policies. If councils and IJBs continue to provide services in the same way, we have estimated that these changes require councils' social work spending to increase by between £510 and £667 million by 2020 (16–21 per cent increase).

3 The integration of health and social care has made governance arrangements more complex, but regardless of integration, councils retain statutory responsibilities in relation to social work services. Elected members have important leadership and scrutiny roles in councils. It is essential that elected members assure themselves that service quality is maintained and that risks are managed effectively. Elected members have a key role to play in a wider conversation with the public about service priorities and managing people's expectations of social work and social care services that councils can afford to provide in the future. The Scottish Government also has an important role to play in setting the overall context of the debate.

4 With integration and other changes over recent years, the key role of the chief social work officer (CSWO) has become more complex and challenging. Councils need to ensure that CSWOs have the status and capacity to enable them to fulfil their statutory responsibilities effectively.

current approaches to delivering social work services will not be sustainable in the long term

Key recommendations

Social work strategy and service planning

Councils and IJBs should:

- instigate a frank and wide-ranging debate with their communities about the long-term future for social work and social care in their area to meet statutory responsibilities, given the funding available and the future challenges (paragraph 111)
- work with the Scottish Government, their representative organisation (COSLA or the Scottish Local Government Partnership (SLGP)), Social Work Scotland and other stakeholders to review how to provide social work services for the future and future funding arrangements (paragraphs 35–41)
- develop long-term strategies for the services funded by social work by:
  - carrying out a detailed analysis of demographic change and the contribution preventative approaches can make to reduce demand for services (paragraph 52)
  - developing long-term financial and workforce plans (paragraph 81)
  - working with people who use services, carers and service providers to design and provide services around the needs of individuals (paragraphs 69–72)
  - working more closely with local communities to build their capacity so they can better support local people who may be at risk of needing to use services (paragraph 112)
  - considering examples of innovative practice from across Scotland and beyond (paragraphs 54, 67–68)
  - working with the NHS and Scottish Government to review how to better synchronise partners' budget-setting arrangements to support these strategies (paragraph 36).

Governance and scrutiny arrangements

Councils and IJBs should:

- ensure that the governance and scrutiny of social work services are appropriate and comprehensive across the whole of social work services, and review these arrangements regularly as partnerships develop and services change (paragraphs 87– 93)
- improve accountability by having processes in place to:
  - measure the outcomes of services, for example in criminal justice services, and their success rates in supporting individuals' efforts to desist from offending through their social inclusion
  - monitor the efficiency and effectiveness of services

  - allow elected members to assure themselves that the quality of social work services is being maintained and that councils are managing risks effectively
  - measure people's satisfaction with those services
  - report the findings to elected members and the IJB (paragraph 90, 108–109).

Councils should:

- demonstrate clear access for, and reporting to, the council by the CSWO, in line with guidance (paragraphs 104–106)
- ensure the CSWO has sufficient time and authority to enable them to fulfil the role effectively (paragraphs 102–107)
- ensure that CSWO annual reports provide an annual summary of the performance of the social work service, highlighting achievements and weaker areas of service delivery, setting out the council's response and plans to improve weaker areas and that these are actively scrutinised by elected members (paragraphs 108–110).

Workforce

Councils should:

- work with their representative organisation (COSLA or the SLGP), the Scottish Government and private and third sector employers to put in place a coordinated approach to resolve workforce issues in social care (paragraphs 21–23)
- as part of their contract monitoring arrangements, ensure that providers who use zero hours contracts allow staff to accept or turn down work without being penalised (paragraph 24).

Service efficiency and effectiveness

Councils and IJBs should:

- when planning an initiative, include evaluation criteria and extend or halt initiatives depending on the success of new approaches in improving outcomes and value for money (paragraphs 53–53)
- work with COSLA to review the eligibility framework to ensure that it is still fit for purpose in the light of recent policy and legislative changes (paragraphs 46–47)

Councils should:

- benchmark their services against those provided by other councils and providers within the UK and overseas to encourage innovation and improve services (paragraphs 54, 67–68).

Introduction

1. Scottish councils' social work departments provide and fund essential support to some of the most vulnerable people in society. They supported and protected over 300,000 people in 2014/15, around 70 per cent of whom were aged 65 and over.[1] Social work departments also provide and fund social care, for example care at home for older people who require help with dressing and taking medication. People supported by social work and social care in Scotland in 2014/15 included:

- 15,404 looked-after children (LAC), that is children in the care of their local authority
- 2,751 children on the child protection register, a list of children who may be at risk of harm[2]
- 61,500 people who received homecare services[3]
- 36,000 adults in care homes.[4]

2. In 2014/15, councils' net expenditure on social work was £3.1 billion.[5] Net spending is total spending less income, for example from charges for services. Just over 200,000 people work in social work and social care, around one in 13 people in employment in Scotland.[6] Many are employed in the private and third sectors that councils commission to provide services.[7] In addition, the Scottish Government estimates that there are 759,000 unpaid carers aged 16 and over in Scotland, 17 per cent of the adult population, and 29,000 young carers under 16.[8]

3. Social work services have recently been reorganised. The Public Bodies (Joint Working) (Scotland) Act 2014 requires councils and NHS boards to create an integration authority to be responsible for the strategic planning of adult social care services, some health services and other functions delegated to it. It is also responsible for ensuring the delivery of those functions. The Integration Joint Board (IJB) also has an operational role as described in the locally agreed operational arrangements set out within their integration scheme. The Act also allows councils to integrate children's and families' services and criminal justice social work.

4. Councils delegate their responsibility for strategic planning of adult social services, and any other services they have decided to include, to the integration authority. All council areas, apart from Highland, have created an IJB to plan and commission integrated health and social care services in their areas. The voting membership of IJBs comprise equal numbers of council elected members and NHS board non-executive directors. Our recent report *Health and social care integration* includes a description of the integration arrangements in each council area.[9]

5. The Scottish Government sets the legislative basis and the overall strategic framework for the delivery of social work. Its overall vision is 'a socially just Scotland with excellent social services delivered by a skilled and valued workforce which works with others to empower, support and protect people, with a focus on prevention, early intervention and enablement'.[10] The Scottish Government also sets the key outcomes that councils' social work services are expected to contribute to achieving, for example 'Our people are able to maintain their independence as they get older and are able to access appropriate support

when they need it.' This report focuses on councils' social work services, but recognises the role of the Scottish Government in setting the overall context in which councils operate.[11]

About the audit

6. The overall aim of the audit was to examine how effectively councils are planning to address the financial and demographic pressures facing social work. The objectives were to assess:

- the scale of the financial and demand pressures facing social work
- the strategies councils are adopting to meet these challenges
- the effectiveness of governance arrangements, including how elected members lead and oversee social work services
- the impact of financial and demand pressures on people who use services and on carers, and how councils involve them in planning how services are provided.

7. Social work comprises a wide range of services, and we have not covered all of them in this report. We also did not examine health and social care integration arrangements, which will be the subject of separate audit work, but we did consider their impact on councils' financial, operational and governance arrangements. Our methodology included:

- fieldwork interviews with elected members, senior managers and social workers in six council areas, Midlothian, East Renfrewshire, Comhairle nan Eilean Siar, Glasgow City, Perth and Kinross and West Lothian
- meetings and focus groups with stakeholders, including:
  - 33 focus groups and 12 interviews with service users and carers (165 participants)
  - four focus groups with service providers (over 40 participants)
  - attending the Coalition of Carers in Scotland Annual General Meeting
- desk research, including analysing both the impact of legislation and policy, and financial and demographic data.

8. Our audit took into account the findings of previous audits including:

- *Commissioning social care* (March 2012)
- *Reshaping care for older people* (February 2014)
- *Self-directed support* (June 2014)
- *Health and social care integration* (December 2015)
- *Changing models of health and social care* (March 2016)

In addition, we are planning further audit work on health and social care integration and following up our report on self-directed support.

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

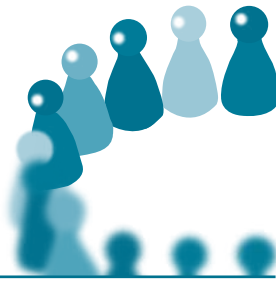
- Supplement 1 presents the findings of our survey of service users and carers.
- Supplement 2 lists advisory group members, who gave advice and feedback at important stages of the audit. It also describes the detailed audit methodology, the roles and responsibilities of the key social work organisations and social work legislation.
- Supplement 3 describes the governance and scrutiny arrangements in each of our fieldwork councils, providing an illustration of the variety and complexity of arrangements across Scotland.
- Supplement 4 is a self-assessment checklist for elected members.

10. This report has three parts:

- Part 1 Challenges facing social work services.
- Part 2 Strategies to address the challenges.
- Part 3 Social work governance and scrutiny arrangements.

Part 1

Challenges facing social work services



Key messages

1 Councils' social work departments provide important services to some of the most vulnerable people across Scotland. But they are facing significant challenges. These include financial pressures caused by a real-terms reduction in overall council spending, demographic changes, and the cost of implementing new legislation and policies. We have estimated that these changes require councils' social work spending to increase by between £510 and £667 million by 2020 (16–21 per cent increase), if councils and IJBs continue to provide services in the same way. Additional funding provided to IJBs via the NHS may partially relieve the financial pressures.

2 Councils are implementing a wide range of legislation and policy changes aimed at improving services, better supporting carers, improving outcomes for people and increasing the wages paid to adult care workers. This has significant financial implications. Councils are also under pressure due to increasing demand associated with demographic changes, particularly people living longer with health and care needs.

3 Since 2010/11, councils' total revenue funding has reduced by 11 per cent in real terms. Social work spending increased by three per cent in real terms over the same period, and now accounts for a third of overall council spending. Further reductions in councils' budgets are an additional pressure on social work services, particularly as their financial commitments continue to increase.

4 Social care providers have difficulty recruiting and retaining suitably qualified staff, particularly homecare staff and nursing staff. However, the number of social workers has increased over recent years.

councils' social work departments provide important services to some of the most vulnerable people across Scotland

Social work is a complex group of services

11. Social work departments provide and fund a wide range of specialist services for children, adults and families, and other specific groups. These services aim to improve the quality of their lives and help people to live more independently (Exhibit 1, page 12). Each of these client groups will include people requiring care, support or protection. For example, through care at home, child protection or helping people overcome addiction. Social workers deal with people with complex problems and with vulnerable people who need support at different

times or sometimes throughout their lives. They often specialise in particular service areas, for example criminal justice, children and families or mental health.

Social work services are implementing a considerable volume of legislation and policy change

12. Since the Scottish Parliament was established, there has been an increase in the volume of legislation related to social work. Councils are currently implementing several important pieces of legislation (Exhibit 2, page 13). This legislation is designed to improve services and the outcomes for people who use them, for example by bringing about increasingly personalised services to meet individuals' needs. However, implementing legislation can increase financial pressures and staff workload in the medium term.

Exhibit 1

Social work and social care services

Social work provides a variety of services to protect and support people in three client groups.

Children's services	Adult services	Criminal Justice services
Support for families	Residential care	Offender services
Child protection	Care at home	Providing social enquiry reports
Adoption services	Day care	Supervision of community payback and unpaid work
Kinship care	Hospital discharge coordination	Supporting families of prisoners
Fostering	Adult support and protection	Supervision of offenders on licence
Child care agencies	Mental health and addiction services	
Looked-after young people	Dementia and Alzheimer's services	
Day care	Supporting people with disabilities	
Residential care	Services to support carers	
Child and adolescent mental health	Provision of Aids and adaptations	
Supporting child refugees	Re-ablement services	
Supporting trafficked children	Supported living	
Support for young people involved in offending behaviour	Supporting refugee families	
Support for children with disabilities and their families	Supporting victims of people trafficking	
	Intermediate care	

Source: Audit Scotland

Exhibit 2

Social work and social care services

Councils are implementing a great deal of legislation, some with significant cost implications.

Legislation	Key features of legislation	Associated costs (from the financial memorandum to the Bills)
Social Care (Self-Directed Support) (Scotland) Act 2013	The Act aims to ensure that adults and children (including carers and young carers) have more choice and control over how their social care needs are met. It stipulates the forms of self directed support (SDS) that councils must offer to those assessed as requiring community care services.	• All local authorities are at different stages in the self-directed support agenda, meaning costs will vary widely.
The Children and Young People (Scotland) Act 2014	The Act makes provisions over a wide range of children's services policy, including 'Getting it Right for Every Child'. It includes: • local authorities and NHS boards having to develop joint children's services plans in cooperation with a range of other service providers • a 'named person' for every child • extending free early learning and childcare from 475 to 600 hours a year for all three and four-year-olds and two-year-olds who have been 'looked after' or have a kinship care residence order • a statutory definition of 'corporate parenting' • increasing the upper age limit for aftercare support from 21 to 26.	Additional annual costs estimated to be: • £78.8 million in 2014/15 • £121.8 million in 2016/17 • £98.0 million in 2019/20 • Cumulative total from 2014-15 to 2019-20 is £595 million.
The Public Bodies (Joint Working) (Scotland) Act 2014	The aim of the Act is to achieve greater integration between health and social care services to improve outcomes for individuals. It also aims to improve efficiency by 'shifting the balance of care' from the expensive acute sector, such as large hospitals, to less expensive community settings. The Scottish Government estimates partnerships should achieve potential efficiencies of £138-£157 million a year by providing support to keep people out of hospital and enabling them to return home as soon as they are well enough.	Costs to health boards and local authorities: • 2014/15: £5.35 million • 2015/16: £5.6 million • 2016/17: £5.6 million.

Cont.

Legislation	Key features of legislation	Associated costs (from the financial memorandum to the Bills)
The Carers (Scotland) Act 2016	The Act aims to improve support to carers by: • changing the definition of a carer so that it covers more people • placing a duty on local authorities to prepare an adult care and support plan or young carer statement for anyone it identifies as a carer, or for any carer who requests one • introducing a duty for local authorities to provide support to carers who are entitled under local criteria • requiring local authorities and NHS boards to involve carers in carers' services • introducing a duty for local authorities to prepare a carers strategy • requiring local authorities to establish and maintain advice and information services for carers.	Estimated additional costs for local authorities are: • £11.3-£12.5 million in 2017/18, rising to £71.8-£83.5 million by 2021/22. • The total estimated impact on councils between 2017/18 and 2022/23 is £245-£289 million.
The Community Justice (Scotland) Act 2016	The Community Justice (Scotland) Bill seeks to establish new arrangements for providing and overseeing community justice. Currently eight community justice authorities (CJAs) bring together a range of agencies to coordinate local services for offenders and their families. They will be abolished and replaced by a model involving national leadership, oversight and support for community justice services by a new body called Community Justice Scotland, funded by, and responsible to, Scottish ministers.	The provisions will have few if any financial implications for local authorities other than during the transitional period.
The UN Convention on the Rights of Persons with Disabilities (UNCRPD) (Scottish framework and delivery plan)	The delivery plan provides a framework to allow people with disabilities to have the same equality and human rights as non-disabled people. It includes legislation, such as Self-Directed Support and the Children and Young People (Scotland) Act 2014. The draft delivery plan groups the UNCRPD articles into four outcomes covering equal and inclusive communication and access to: • the physical and cultural environment, transport and suitable affordable housing • healthcare and support for independent living, with control over the use of funding • education, paid employment and an appropriate income and support whether in or out of work • the justice system.	It is difficult to predict the overall impact in terms of cost, but it may have a significant impact on the way councils deliver services.

Note: Cost information is taken from the financial memorandum that accompanies each Bill.

Source: Audit Scotland

13. In addition to changes in legislation, there have been a number of significant policy developments, some backed by legislation, that require considerable change to the way that social work services are provided. These include:

- Increased personalisation of services – Personalisation of services, for example through self-directed support (SDS), is a major change to the way councils support people with social care needs. The human rights principles of fairness, respect, equality, dignity and autonomy for all form the basis of SDS. Social work professionals need to see people as equal partners in determining their care needs and controlling how they meet their needs. This means they are not limited to choosing from existing services. Social work services may need to move spending away from existing services towards giving people their own budget to spend. This can lead to a reduction in use of some services. However, it can be difficult for councils to withdraw existing underused services because of public and political pressures.

- An increased focus on prevention – The report from the Commission on the Future Delivery of Public Services (the Christie Commission) highlighted the need to transform the way public services are planned and delivered.[12] The report identified prevention, early intervention and providing better outcomes for people and communities as key to this transformation.

- An increased focus on joint working – A series of initiatives over recent years has aimed to encourage a more joined-up approach to health and social care. These include the creation of Local Health Care Cooperatives (LHCCs) in 1999, and their replacement by Community Health Partnerships (CHPs) in 2004. LHCCs and CHPs lacked the authority to redesign services fundamentally.[13] The Public Bodies (Joint Working) (Scotland) Act 2014 aimed to achieve greater integration between health and social care services to improve outcomes for individuals and improve efficiency by 'shifting the balance of care' from the acute sector to community settings.

14. New legislation often has financial consequences and, to allow MSPs to consider the full impact of legislation, a financial memorandum to each Bill sets out the estimated cost of implementation. These are the best available estimates at the time, but have sometimes proved inaccurate. The Scottish Government may fund or partially fund these costs but councils sometimes dispute these estimates and the level of funding required.

15. New legislation can also affect how councils deliver services by creating entitlements to services based on specific criteria. Councils need to respond to these and manage the expectations of people who use services and carers. These entitlements can be based on needs assessments, or on the expected outcomes, or they can create rights to services for particular groups. Transitions are important as entitlements change depending on age. For example:

- Children have the right to specific support that adults may not have. As a result, councils have to be careful in managing the expectations of parents as children reach adulthood.

- People aged over 65 may be entitled to free personal care, but 64-year-olds with similar needs may have to make a financial contribution to their care.

I receive 37 hours of support and seven sleepovers. I get personal care, support with the running of my flat, to shop and support to be involved in the community. They also enable me to attend university.

Service user, physical disabilities

When [grandchild] turned 16 I was told that this Saturday service was going to stop because he would now be under adult services. I had no forewarning, no-one from adult services contacted me; I contacted them and they couldn't offer any support. It's a funding issue.

Carer

Social work services face significant demographic challenges

16. The impact of demographic change on health and social care spending has already been well reported.[14] Between 2012 and 2037, Scotland's population is projected to increase by nine per cent. All parts of the population are projected to increase, but by different amounts:

- the number of children by five per cent
- the working age population by four per cent
- the number of people of pensionable age by 27 per cent.[15]

17. Overall demand for health and social care will depend significantly on the number of older people and the percentage who require care. Although life expectancy continues to increase, healthy life expectancy (HLE), that is the number of years people can expect to live in good health, has not changed significantly since 2008 (Exhibit 3). This means that a larger number of older people may require support for longer, unless HLE increases. Councils and the Scottish Government have taken steps to try to increase HLE. This includes measures to reduce smoking, alcohol consumption and environmental pollution and providing information to the public about the benefits of a healthy lifestyle.

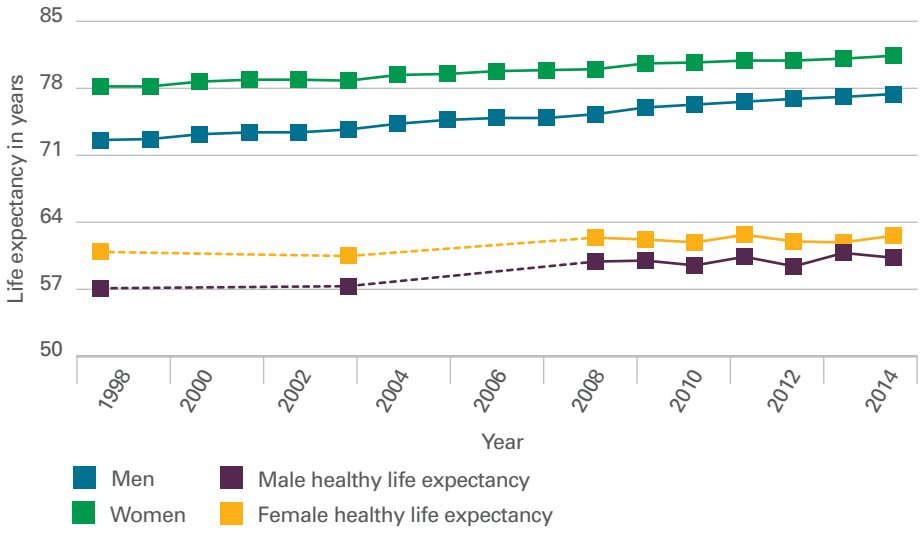
Supporting looked-after children and child protection has increased demand on social work services

18. Looked-after children (LAC) are children in the care of their local authority. They may live in their own home, with foster or kinship carers or in a residential

Exhibit 3

Changes in life expectancy and healthy life expectancy

Life expectancy is increasing faster than healthy life expectancy, potentially increasing service pressures.



Note: Data on healthy life expectancy was not collected annually until 2008.

Source: Scottish Health Survey, Scottish Household Survey, National Records of Scotland births, deaths and populations data

home. Most become looked after for care and protection reasons. The term also includes unaccompanied children seeking asylum and young people who have been illegally trafficked. As at July 2015, 17,357 children in Scotland, around 1.8 per cent of the total, were looked after or on the child protection register.[16,17] Of these 15,404 were looked after, 2,751 were on the child protection register and 798 were both looked after and on the register. While there has been a recent reduction, possibly due to improvements in prevention, the number of LAC has increased by 36 per cent since 2000, although the numbers and trends vary among councils. The number of children on the child protection register increased by 34 per cent between 2000 and 2015, with three in every 1,000 children under 16 now on the register. In smaller councils, the number of children on the register (and resultant workload) can fluctuate significantly, particularly when sibling groups in large families are registered.

19. The reasons for these increases are likely to be complex. Many of the councils we visited think that increases in drug and alcohol use by parents are important factors. Others have seen an increase in reporting of domestic abuse and alcohol-related incidents in more affluent areas that might have gone unreported in the past. In addition, early intervention policies are likely to have led to an increase in the number of looked after children, but a decrease in the time that councils look after them. Early intervention means identifying people at risk and intervening to prevent the risk. Between 2007 and 2014, the number of children removed from the register who had been on it for less than a year increased from 2,421 (79 per cent of the total) to 3,930 (87 per cent). Over the same period, the number of children who had been on the register for more than a year fell from 663 to 569.

Councils and service providers face difficulties in recruiting staff

20. Just over 200,000 people work in social work and social care services, representing around one in 13 people in employment in Scotland.[18] Almost half work part time and 85 per cent are women. The private sector is the biggest employer (42 per cent of staff), followed by the public sector (31 per cent) and the third sector (28 per cent). This distribution varies considerably among councils, and the public sector is the biggest provider in the three island authorities.

21. Many third and private sector providers raised staff recruitment as a significant issue for them. Councils have fewer recruitment problems, the exception being in remote rural areas, where it can be difficult to recruit specialised staff. Third and private sector providers reported that the apparent causes for these difficulties included:

- Low pay – providers in both the private and third sectors felt that the rates councils pay under their contracts only allowed them to pay staff at, or near, the minimum wage. In addition, travel time between clients is sometimes unpaid.
- Antisocial hours – providing homecare often requires carers to assist people to get out of bed in the morning and into bed at night. This can mean weekend working, split shifts and antisocial hours, with no additional pay. The increased personalisation of care has contributed to this as carers increasingly provide care to suit individuals, rather than fitting individuals into the care system.

> **Driving down costs to the extent that staff are recognised as being in a 'low wage sector' increases the problem of recruitment.**
>
> Service provider

- **Difficult working conditions** – staff have to take care of people with a variety of care needs that some find difficult, for example, assisting people with bathing and personal hygiene, or who have dementia or incontinence.

22. The cycle of continually recruiting and training staff is costly and could potentially have an impact on the quality of services provided. Service provider focus groups highlighted a need to provide staff with a sustainable career path to improve recruitment and retention. Overall, the public sector has the most stable workforce and the private sector the least, although this does not appear to be the case for all categories of staff (Exhibit 4).[19]

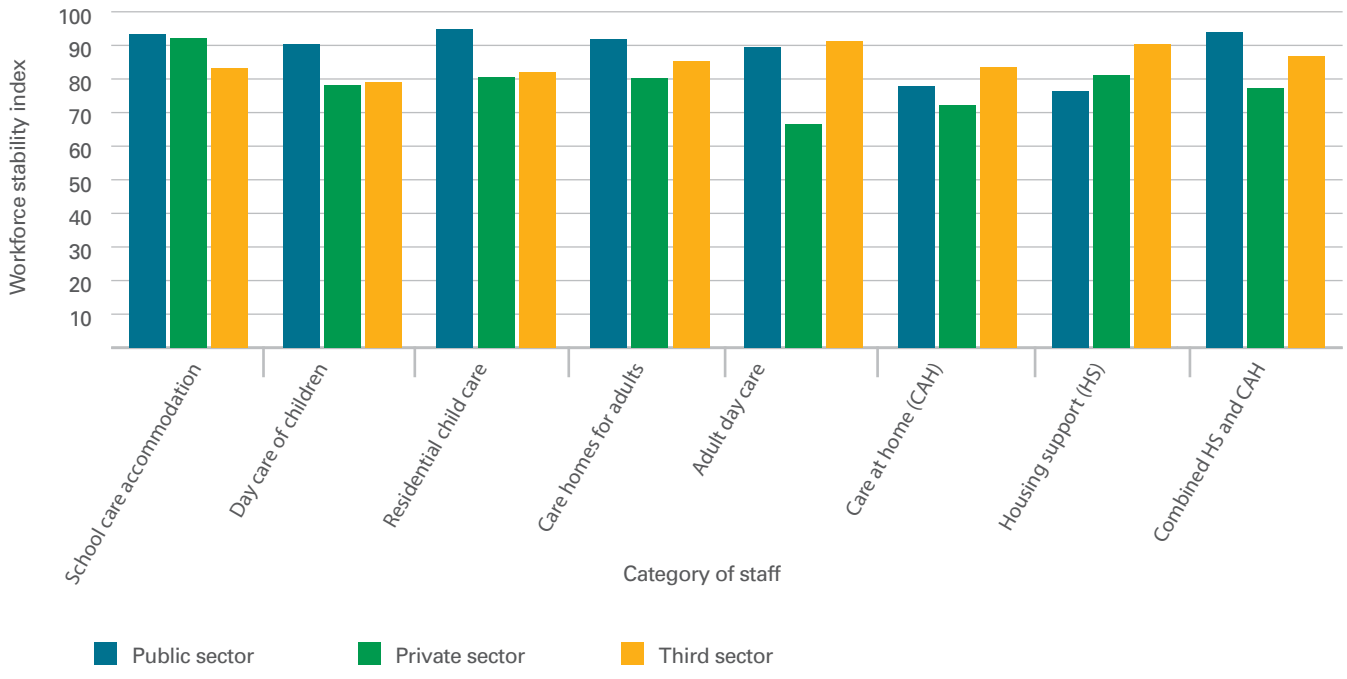
23. Some care providers expressed concerns that leaving the EU and the potential introduction of a points-based immigration system could create problems for staff recruitment. A 2008 workforce survey indicated that 6.1 per cent of the social care workforce in Scottish care homes for older people were EU – non-UK workers, and a further 7.3 per cent were employed under work permits. Most of those employed from within the EU came from Poland and the Czech Republic and those from outside the EU were from the Philippines, India and China.[20]

24. Four per cent of the workforce have a no guaranteed hours (NGH) contract.[21] When combined with the other contract types that may be considered a zero hours contract (bank and casual or relief), they comprise roughly ten per cent of the contracts in the workforce. Providers believe zero hours contracts are

Exhibit 4

Social work workforce stability 2013/14

The public sector workforce is generally the most stable.



Note: Because of data limitations, the SSSC cannot provide an accurate estimate for turnover. However, they are able to calculate a 'stability index' of staff who are still in post after a year. If the index is 90 per cent it means that 10 per cent of staff present at the start of the period are no longer present. It is important to note that this does not mean that turnover is 10 per cent as the measure excludes staff who joined and left within the period under consideration.

Source: Scottish Social Services Council (SSSC)

essential to provide a flexible and personalised service to people, while also providing flexibility for staff. These contracts are suitable as long as they are not exclusive and staff are free to accept or turn down work without being penalised. As part of good contract management, councils should ensure that providers use zero hours contracts properly.

25. There are skills and staffing shortages in several areas of social work and social care, including:

- Homecare staff – 69,690 people work in housing support or care at home.[22] Both third sector and private sector providers find it difficult to recruit staff. Rapid staff turnover is a significant threat to maintaining service standards, particularly in adult day care.

- Nursing staff – 6,620 registered nurses work in the care sector, 4,930 of them in adult care homes. Ninety-one per cent of registered nurses are in the private sector. Care providers in both the private and third sectors are having trouble recruiting qualified nursing staff for care homes. As a result, providers were trying to recruit staff from outside the UK. Although data is not collected on vacancy rates for nursing staff in the care sector, there were 2,207 whole-time equivalent (WTE) vacant nursing and midwifery posts in the NHS in Scotland at 31 March 2016.[23]

- Mental health officers (MHOs) – are specialist social workers with a statutory role in the detention and treatment of people with mental illness. They look into the circumstances of individuals where people have concerns about their mental health. They can apply for a court order that would allow an individual to be taken to a 'place of safety' for up to seven days.[24] In December 2014, the number of registered MHOs was at its lowest level since 2005. However, in 2015 there was a small increase (two per cent) to create a total of 670 practising MHOs. In 2015 there were 15 unfilled posts for MHOs in Scotland and 17 further post holders who were unavailable, for example through career breaks or secondments, about five per cent of the total.[25]

The professional social work role is changing

26. The workforce includes 11,127 professional social workers registered in Scotland. Almost three-quarters, 8,242, work in councils and 2,040 (18 per cent) are employed by other providers. Most of the rest are self-employed, unemployed or recently retired. Not all qualified social workers work in roles where they are required by law to hold a social work qualification (statutory roles), for example they may work in management roles. The number of WTE social workers employed by councils in statutory roles increased significantly between 2001 and 2015, from 3,873 to an estimated 5,630. Of these, 31 per cent work with adults, 49 per cent with children, 15 per cent in criminal justice; five per cent work generically.[26]

27. The majority of social workers in our focus groups were optimistic about their role and their ability to make a positive difference to people's lives. Changes in structural and partnership arrangements in health and social care have introduced more working in multidisciplinary teams, for example with health visitors or occupational therapists. Social workers sharing offices with other disciplines can be both rewarding and effective. We found that social workers who had worked in multidisciplinary teams for some time were convinced that improved

communication with community NHS staff had improved services. However, some were concerned about erosion of their professional identity. Moreover, adapting to working with colleagues from a different culture, for example in approaches to risk, could be challenging.

Unpaid carers provide the majority of social care in Scotland

28. The Scottish Government estimates that there are 759,000 unpaid carers aged 16 and over in Scotland, around 17 per cent of the adult population. Of these, 171,000 (23 per cent) provide care for 35 hours or more a week. In addition, there are an estimated 29,000 young carers under 16, around four per cent of the under 16 population.[27] There are many more unpaid carers providing support to people than those in the paid social services workforce.

29. In 2010, the Scottish Government reported that unpaid carers saved health and social services an estimated £7.68 billion a year.[28] More recently, Carers UK estimated the value of unpaid care in Scotland to be £10.8 billion, more than three times current social work net spending.[29]

30. The Carers (Scotland) Act 2016 became law in March 2016. It provides for the planning and provision of support, information and advice for unpaid carers and encourages councils to become involved in carers' services. It also means councils are required to prepare a carer support plan for carers, including young carers, who want one. A carer support plan sets out information about the carer's circumstances, the amount of care they are able and willing to provide, the carer's needs for support and the support available. The Act also requires each council to establish and maintain an information and advice service for carers who live or care for people in its area.

> **(Unpaid) Carers do everything! Link everything! Anchor everything!**
>
> Carer

> **24/7 carers are there, understanding the person's needs.**
>
> Carer

Social work services are facing considerable financial pressures

31. In 2014/15, councils' net spending on social work services was £3.1 billion (Exhibit 5, page 21). Services for older people made up around 44 per cent of this spending, and services for children and families around 28 per cent. A range of other services make up the remainder.

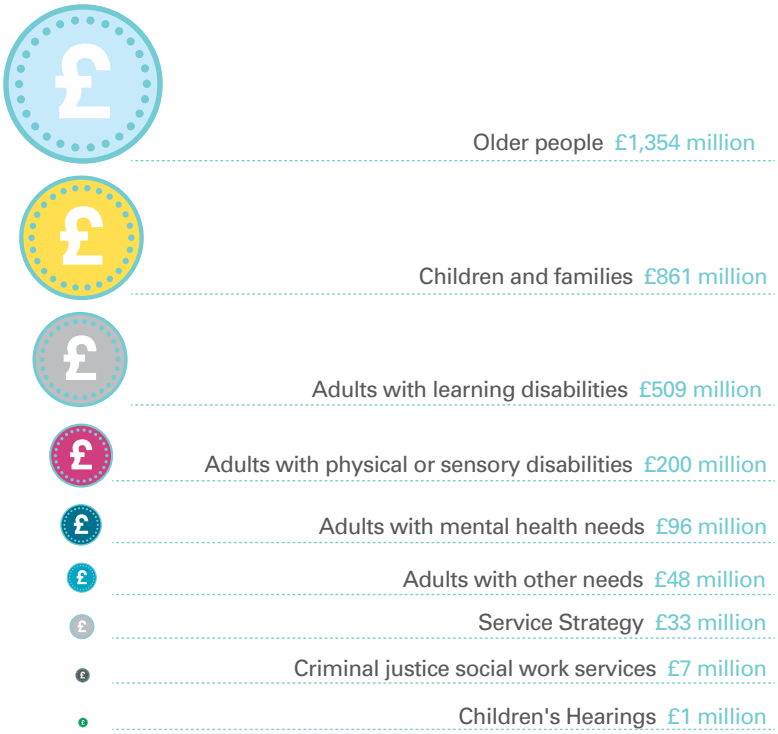
32. In 2016/17, councils' total revenue funding, that is the funding used for day-to-day spending, will be five per cent lower than in 2015/16. This is a reduction of 11 per cent in real terms since 2010/11.[30] This is a significant pressure on all council services, including social work. The 2016/17 figure does not include £250 million that the Scottish Government allocated to health and social care integration authorities to support social care, because the Scottish Government routed it through the NHS boards' budgets rather than council budgets.

33. Against the trend of falling council spending, councils' total social work net spending increased in real terms from £3.2 billion to £3.3 billion between 2010/11 and 2014/15, an average increase of 0.8 per cent a year.[31] As a result, spending on social work increased from 28.9 per cent to 32 per cent of council spending.[32] An analysis of council accounts found that two-thirds of councils reported social work budget overspends totalling £40 million in 2014/15. Most councils identified homecare services for adults and older people as the service under most pressure.

Exhibit 5

Social work spending, 2014/15

Around 44 per cent of the £3.1 billion net social work spending is on services for older people and this percentage is likely to increase with demographic change.



Source: Local Government Financial Statistics 2014-15 (Annex A), February 2016

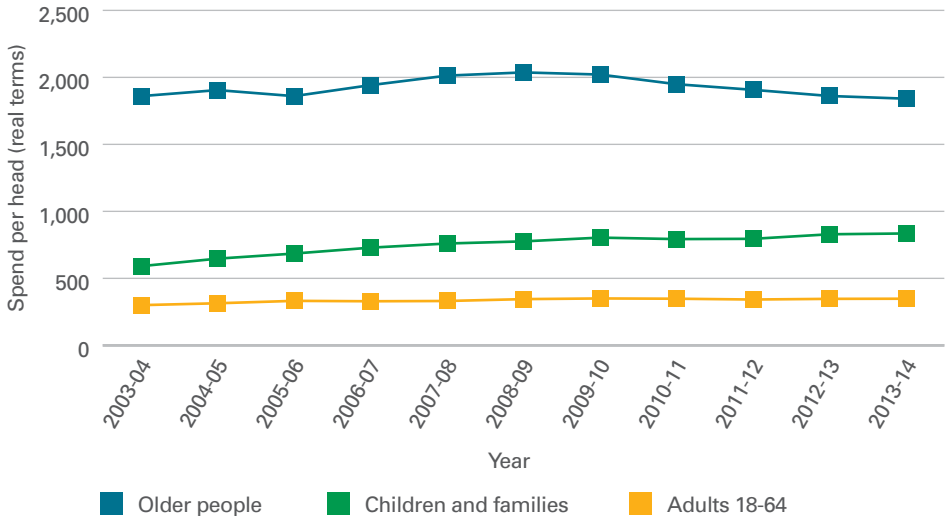
34. There have been significant long-term changes in spending per head among different age groups (Exhibit 6, page 22). The reduction in spending on older people is a combination of a lower percentage of older people receiving services (paragraph 46) and a reduction in the real-terms cost of care homes (paragraph 62) and homecare (paragraph 59). The increase in spending on children and families may be related to an increase in the number of looked after children, an increase in the complexity of children and families' cases and an increased focus on early intervention.

Few councils and IJBs have long-term spending plans for social work

35. We examined council budgets and spending plans for 2015/16, 2016/17 and beyond to assess whether the trends identified above are likely to continue in the medium term. Budget information is more difficult to collect and interpret than historic expenditure information because councils do not present this information consistently. In addition, most IJBs had not finalised their budgets at the time we were conducting our analyses. Budgets for 2016/17 were very similar to 2015/16 in cash terms. We also analysed councils' savings plans. Councils plan to save £54 million from social work budgets in 2016/17, mainly through changing how they provide services, reducing services and making efficiency savings.

Exhibit 6

Real-terms spending on social work services per head, 2003/4 to 2013/14



Source: Expenditure on Adult Social Care Services, Scotland, 2003/4 to 2013/14, Scottish Government

36. Councils and NHS boards work on different financial planning cycles and agree budgets at different times of the year. A survey of IJBs by the Scottish Parliament's Health and Sport Committee found that over half of IJBs were unable to set a budget for 2016/17 before June 2016, and over a quarter before August 2016.[33] A number of responses mentioned delays in receiving the health allocation for the partnership as a cause of difficulty in setting budgets. If councils and NHS boards continue with different budget cycles, it will make it more difficult for IJBs to agree budgets for services in a timely way.

37. In February 2016, as part of the local government settlement, the Scottish Government announced funding of £250 million to support social care for the three years to 2018/19. Some of this funding was to help pay the Living Wage (£8.25 an hour) to all care workers in adult social care, regardless of age from 1 October 2016.

38. The Living Wage Foundation sets the Living Wage. It is up-rated annually and they will announce a new rate in November. The local government settlement does not require councils to increase wages to the new Living Wage rate when the Living Wage Foundation announces it in November.

39. The Scottish Government has estimated that over the period 2012-32, spending on social care for older people will need to increase by between 1.5 per cent and 3.3 per cent a year, depending on changes to healthy life expectancy (HLE).[34] We have calculated lower and upper limits of the cost of demographic change based on Scottish Government projections. Added to this are cost pressures arising from legislation, based on their financial memorandums, and the cost implications of the commitment to the Living Wage for care workers (Exhibit 7).[35]

Exhibit 7

Potential financial pressures facing Scottish councils by 2019/20

Councils face significant cost pressures.

Reason for cost increase	Lower limit (£ million)	Upper limit (£ million)
Demographic change (older people only)	£141	£287
The Children and Young People (Scotland) Act 2014	£98	£98
The Carers (Scotland) Act 2016	£72	£83
The Living Wage	£199	£199
Potential cost increase by 2019/20	**£510**	**£667**

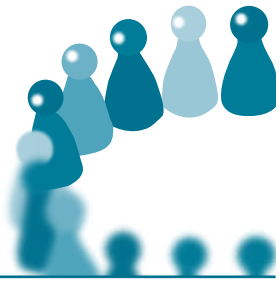
Source: Audit Scotland analysis of financial memorandums and information provided by the Scottish Government

40. Together they imply increases in social work spending of between £510 and £667 million (a 16–21 per cent increase) by 2019/20. Additional Scottish Government funding to implement legislation and to IJBs (via the NHS) may partially relieve some of these pressures, as could potential savings from health and social care integration and by providing services differently.

41. Councils and IJBs need to develop longer-term financial strategies and plans for social work services, taking into consideration the above financial pressures. For example, they need to assess the affordability of options for changing the way they deliver services, so that elected members can consult the public and make informed decisions. Some of the councils we visited had already done this. For example, West Lothian Council had detailed projections of cost pressures for the client groups in social work and had considered the options available to meet those pressures depending on the level of funding available.

Part 2

How councils are addressing the challenges



Key messages

1 Councils have adopted a number of strategies to achieve savings. They have tightened eligibility criteria so that fewer people receive services and targeted funding to people in greatest need. They have also achieved significant savings in the cost of homecare and care homes through competitive tendering and the national care home contract.

2 Current approaches will not be sustainable given the scale of the challenge, and there are risks that reducing costs further could affect the quality of services. Fundamental decisions are required on long-term funding and social work service models for the future.

3 There has been a limited shift to more prevention and different models of care. Many councils have taken an opportunistic or piecemeal approach to changing how they deliver services, often to meet financial challenges or as the result of initiative funding by the Scottish Government.

4 Opportunities for people who use social work services and carers to be involved in planning services are limited. There is scope for councils and IJBs to do more to work with them to design, commission, deliver and evaluate services to achieve better outcomes. Service providers also have an important role to play in commissioning services, and councils are not doing enough to work with them to design services based around user needs.

5 People who use services and their carers value the support they get from social work and social care services. Our focus groups had a number of concerns about homecare, such as shorter visits and people using services seeing a number of different carers.

6 The Scottish Government's Living Wage commitment provides an opportunity to improve recruitment and retention of social care staff, and to create a more stable skilled workforce. But it adds to the financial pressures on councils and providers.

fundamental decisions are required on long-term funding and social work service models for the future

Councils, COSLA and the Scottish Government have agreed approaches intended to address major long-term pressures

42. Social work services operate within a number of national strategies, developed by the Scottish Government and councils that are intended to

respond to the major challenges set out in Part 1, such as demographic change, personalisation and prevention. These include:

- **Social Services in Scotland: a shared vision and strategy for 2015-2020** – this builds on the *21st Century Social Work Review* published in 2005. It covers the whole of social work and its aims include:
  - encouraging a skilled and valued workforce
  - working with providers, people who use services and carers to empower, support and protect people
  - a focus on prevention, early intervention and enablement.[36]
- **The 2020 Vision for Health and Social Care in Scotland** envisages that by 2020 people will live longer healthier lives at home, or in a homely setting and that Scotland will have an integrated health and social care system with a focus on prevention and supported self-management.[37]
- **Reshaping Care for Older People** (RCOP) – a ten-year change programme focused on giving people support to live independently in their own homes and in good health for as long as possible. In 2011/12, the Scottish Government introduced the Change Fund, totalling £300 million to 2014/15, specifically to develop this area of policy.[38]

43. Our report, *Reshaping care for older people* commented on slow progress of RCOP and the need to monitor its impact. It also reported that initiatives are not always evidence-based or monitored and that it was not clear how councils would sustain and expand successful projects.[39] Our report *Changing models of health and social care* concluded that the shift to new models of care is not happening fast enough to meet the growing need, and the new models of care that are in place are generally small-scale and not widespread.[40]

Councils have changed eligibility criteria to reduce the number of people who qualify to receive services to balance their budgets

44. Councils have a statutory duty to assess people's social care needs. If they assess a person as needing support and eligible to receive services, they must provide or pay for services to meet these needs.[41] If people are eligible for support, the Social Care (Self-Directed Support) (Scotland) Act 2013 also requires councils to offer people a choice of four options in how their social care is provided:

- a direct payment – this allows people to choose how their support is provided, and gives them as much control as they want over their individual budget
- direct the available support – the person asks others to arrange support and manage the budget
- the council arranges support – the councils choose, arrange and budget for services
- a mix of all the above options.

45. To balance their budgets, councils prioritise funding and staff to those people most in need by setting eligibility criteria and assessing each person's needs against these criteria. Councils have discretion on the thresholds for care they use locally. The level set in each council will depend on the resources available and

> **I have a say about who is on my team. I got to meet them and do interviews. I did the questions in advance.**
>
> Service user, young person with physical disabilities

on the council's policies and priorities. Councils assess people's needs using a common framework of four eligibility levels:

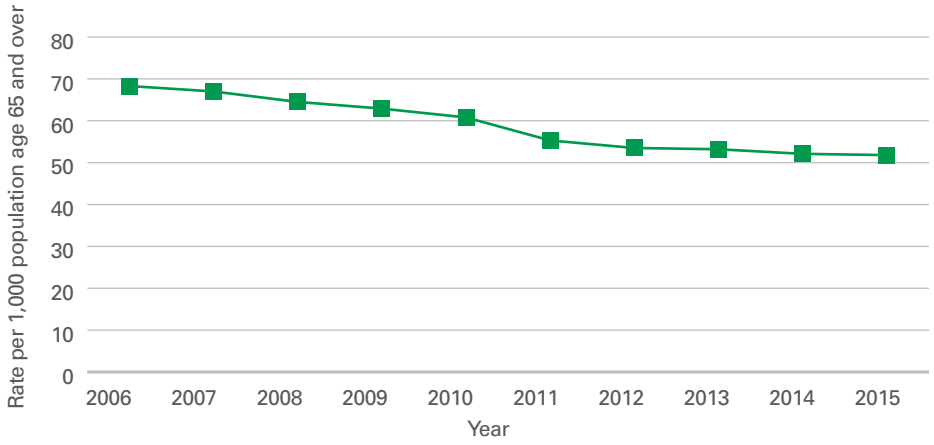
- **Critical Risk (high priority)** – Indicates major risks to an individual's independent living or health and wellbeing likely to require social care services 'immediately' or 'imminently'.
- **Substantial Risk (high priority)** – Indicates significant risks to an individual's independence or health and wellbeing likely to require immediate or imminent social care services.
- **Moderate Risk** – Indicates some risks to an individual's independence or health and wellbeing. These may require some social care services that care providers manage and prioritise on an ongoing basis, or they may simply be manageable over the foreseeable future with ongoing review but without providing services.
- **Low Risk** – Indicates that there may be some quality of life issues, but low risks to an individual's independence or health and wellbeing with very limited, if any, requirement for social care services. There may be some need for alternative support or advice and appropriate arrangements for review over the foreseeable future or longer term.[42]

46. Because of funding pressures, most councils now only provide services to people assessed as being at critical and substantial risk. Focusing services on people with higher levels of need resulted in a reduction in the percentage of older people receiving homecare between 2006 and 2015, from just under 70 per 1,000 population to 50 per 1,000 (Exhibit 8). Of the councils we visited, only West Lothian still provides services to people assessed as at moderate risk.

Exhibit 8

Proportion of people aged 65+ receiving homecare, 2006 to 2015

The proportion of people aged 65 and over receiving homecare has fallen from just under 70 per 1,000 to just over 50 per 1,000.



Source: Expenditure on Adult Social Care Services, Scotland, 2003-04 to 2013-14, Scottish Government

47. Because most councils no longer provide services to people in the two lower risk eligibility criteria, and because of the considerable financial and legislative changes in social work since the current framework was developed, it may be an opportune time for COSLA and councils to review the framework to ensure that it is still fit for purpose.

48. Some councils have also limited the level of service they provide in some areas. Examples from our fieldwork include reducing the length of carer worker visits, providing ready meals and frozen meals, with one hot meal per day (leaving snacks for other meals) and restricting showers to once or twice a week for some people.

Councils are finding it hard to fund a strategic approach to prevention

49. Developing a strategic approach to prevention is essential for councils to sustain provision of social services. In 2011, the Christie Commission concluded that Scotland needed to 'devise a model of public services that is both financially sustainable and is capable of meeting the significant longer-term challenges'. It also proposed that a radical shift towards preventative public spending was essential. In September 2011, the Scottish Government set out an ambitious vision to enable everyone to live longer, healthier lives at home or in a homely setting by 2020.[43] Central to the vision is a focus on prevention, anticipation and supported self-management. The Scottish Government also set up change funds to stimulate prevention work, specifically in the areas of early years, re-offending and re-shaping care for older people.

50. Councils, IJBs and other stakeholders all believe that prevention is the key to meeting the growing demands for social work services within finite resources. However, the councils we visited varied in how well they are developing and implementing preventative strategies. Some, including West Lothian and East Renfrewshire, have a strong focus on prevention, for example they maintain prevention budgets and build prevention into how they plan and provide services. Councils cited various challenges to shifting service models towards prevention:

- a lack of funding because resources are locked into current service models to meet existing demands and savings may not materialise for several years after implementation
- a lack of social worker time – a concern that social work has become crisis based
- managing relatives' expectations – for example, some relatives prefer the council to provide a full care package of residential care rather than have their relation go through a re-ablement programme to allow them to live more independently at home
- community resistance – for example, opposition to closing a local hospital or care facility to free up funding for more accessible community-based care
- cultural differences between councils and the NHS – a common perception among a number of social workers in our focus groups is that the NHS is more risk averse and less used to giving staff responsibility to take the initiative on the care of individuals.

> **I had an OT (occupational therapy) assessment, and social work and they gave me 15 minutes of care. It's really not enough time. It's the choice between getting washed or getting dressed**
>
> Service user, physical disabilities

51. Councils have commonly adopted some prevention initiatives, most of which are effective in the short term, but examples of long-term initiatives are more limited. Common prevention activities included:

- Re-ablement – involves encouraging people using services (often people leaving hospital) to develop the confidence and ability to live more independently and be less reliant on social care. This is usually a six-week programme of intensive help; it commonly results in people requiring less or even no ongoing support. Glasgow City Council found that 30 per cent of clients had no further need of a service following a period of re-ablement. The change fund initially funded this project but the council now funds it as the savings justify the investment.

- Using technology to enable people to continue living in their own homes for longer and to give reassurance to their carers and families. All councils provide a community alarm service. More advanced telecare systems use movement sensors and smoke detectors to alert the service to potential problems or prompt people to take medication. For example, West Lothian Council uses technology to help people with dementia, their families and carers manage issues that may arise in and around the home. Examples include:
  - a GPS device to help relatives or carers to find a vulnerable person if they get lost
  - extreme temperature and flood sensors fitted in kitchens
  - sensors to alert a carer when the person gets out of bed
  - removable sensors, called 'just checking', placed at doorways to monitor movement and assess lifestyle patterns.

- Early intervention for children and families is another widely implemented approach. Social work services work with relevant partners to support children and families at risk of needing support that is more intensive in future, or with older children at risk of becoming an offender. Midlothian Council attributed a significant drop in the number of their children on the child protection register from 158 in 2011 to 29 in 2015, at least partially, to early intervention and prevention work.[44]

- Restricting out of area service for looked-after children – out of area placements tend to involve young people with troubled histories and challenging behaviour and children with significant learning disabilities. Some out of area placements will be the most suitable for a child, such as where the child has complex treatment needs that the council cannot meet or to ensure they can be effectively safeguarded. However, such placements are very expensive (weekly fees to independent providers range from £800 to £5,500) and can have negative consequences. For example, children may try to run away, putting themselves at risk, and children away for long periods will lose contact with their peers and find it difficult to re-integrate into the local community when they leave care.[45] Our fieldwork councils reported that keeping children local to their communities, for example in supported foster placements, could achieve better outcomes for children and achieve considerable financial savings for the council.

I have a feature that picks up if I get out of bed for too long, in case I've fallen in the night. I like to get up and wander about if I can't sleep, and then there is this booming voice asking if I am OK! It's a first class service.

Service user, older person

Councils need to measure the impact of prevention initiatives more systematically

52. Measuring and evaluating the success of prevention work is difficult. By its very nature, it is not easy to quantify what has not happened because of

prevention. It is also hard to attribute outcomes to specific courses of action in an environment where many factors are involved. Even so, councils do not always systematically evaluate initiatives, and there is a risk that opportunities for improvement, making savings or stopping ineffective activity are lost. Councils and IJBs should bring together information on the evaluation of successful prevention initiatives. They can use this to make long-term strategic investment decisions towards prevention as a key part of their long-term budget planning, rather than relying on short-term initiative funding as at present. Prevention needs to be seen as an integral part of councils' and IJBs' overall long-term strategies for services they can continue providing over the long term, rather than an add-on financed by short-term funding.

53. In our fieldwork, we found examples of successful evaluation. An evaluation of Glasgow's Recreate service to support ex-offenders found that in 2014/15 it generated a Social Return on Investment of between £6.14 and £9.54 per £1 invested (Case study 1).[46]

Case study 1

Glasgow Recreate

This service gives ex-offenders the chance to volunteer for up to six months in meaningful roles where they gain new skills and experiences to help them to move forward in their life. Volunteers can access various opportunities, including landscaping and gardening, painting and decorating, retail and warehousing, and woodwork.

With the support of skilled tradespeople, they work on projects for organisations such as community groups, charities, housing associations, and Glasgow Land and Environmental Services. Each volunteer has a dedicated mentor who helps them to access additional volunteering opportunities, housing support, employability services, and money advice and make positive changes in their personal life. They also help volunteers to complete CVs, identify training and development needs, and set goals to help them become more work-ready to help them break the cycle of re-offending.

Volunteers benefit from rail, bus and subway travel, lunch, gym membership, training and development, information about other organisations, and employment support. During 2015/16, there were 58 volunteers in the scheme (up from 34 in 2013/2014), 57 per cent of whom moved into employment. Ninety-six per cent of participants did not re-offend and of those who did, the frequency and severity of the offending was reduced.

Source: Glasgow City Council

Recreate is a good mix of volunteering, learning and mentoring. I worked hard and it paid off.

Recreate volunteer

54. Some councils are learning from experience elsewhere to tackle particular issues. For example, East Renfrewshire Council visited Shropshire County Council to explore how it developed a community-led social work service. It has agreed to be one of three organisations that will pilot the programme in Scotland. There is scope for councils to do more to look at what others are doing, nationally and internationally, and share experience and learning.

Councils have achieved savings through competitive tendering

Councils purchased around £1.6 billion of services in 2014/15

55. Currently, councils spend around £1.6 billion a year on outsourced social care services, roughly two-thirds to the private sector and a third to the third sector (Exhibit 9). Spending on private sector services is mainly to provide homecare, residential care and nursing homecare for older people (£800 million). Most third sector spending is to provide services for children with disabilities (£244 million). Larger providers provide services across a large number of councils and are in a good position to identify good practice.

56. In procuring services, councils need to take into account the long-term financial viability of care providers. Providers could be put at risk by a combination of several factors, including:

- a fall in the number of care home residents
- increased paybill costs because of knock-on impacts of Living Wage
- increased uncertainty following Brexit may make it difficult for private sector providers to finance capital investment, such as building or refurbishing care homes.

Exhibit 9

Breakdown of contracted out social care spending by sector, 2014/15

Most private sector services are for adults while the third mostly sector provides services for children.

		Third sector £'000	Private sector £'000	Total £'000
Social care adult	Day care	43	1,113	1,156
	Homecare	18,290	261,403	279,693
	Mental health services	14,297	12,974	27,272
	Nursing homes	19,273	318,376	337,649
	Residential care	1,883	219,962	221,845
Social care children	Adoption	23,208	35,871	59,079
	Childcare services	49,481	30,217	79,698
	Domestic violence	3,229	41,511	44,740
	Children with disabilities	243,878	17,831	261,708
Social care other		195,945	112,363	308,308
Total		**569,527**	**1,051,621**	**1,621,148**

Note: 'Other' includes advice and counselling services, advocacy service providers, alcohol and drug rehabilitation, community centres, community projects, disability and special needs service providers.

Source: Spikes Cavell database

57. Councils and Scotland Excel need to monitor the financial health of providers as part of their contract monitoring activity. The failure of a provider could have significant consequences for care services as well as people who use care services because Section 12 of the Social Work (Scotland) Act 1968 places a duty on Scottish local authorities to provide or arrange care for any individual in their area who requires assistance in an emergency.

Competitive tendering has reduced the cost of homecare

58. Councils have achieved significant financial savings through outsourcing services such as homecare to the private and third sectors through competitive tendering and re-tendering contracts. The percentage of homecare provided directly by council staff has fallen steadily, both in terms of the number of clients served and the number of hours provided (Exhibit 10, page 32).

59. Between 2010/11 and 2014/15, the average cost of providing homecare to people aged over 65 fell by 7.2 per cent in real terms, to £20.01 per hour.[47] An unintended consequence of driving down spending is increased staff turnover, as private and third sector providers employ staff on poorer terms and conditions than some other large employers or councils.

Too many (paid) carers – regular new carers needing shown ropes again! Gah!!

Unpaid carer

60. Third sector and private sector providers in our focus groups described some councils' procurement processes as inefficient and wasteful. They highlighted inconsistencies in how councils used framework agreements. These are agreements with suppliers to establish the terms that will govern contracts that councils may award during the life of the agreement.[48] Some private sector providers were concerned that they had invested time and money in signing up to frameworks, only to find that councils did not use their services.

Councils have made savings in the cost of care home services

61. The National Care Home Contract sets out the cost to councils of care home placements into private or third sector care homes. COSLA negotiates the fee structure annually with the representative bodies for private and third-sector providers in Scotland.[49] These bodies are Scottish Care and the Coalition of Care and Support Providers in Scotland. The contract includes an additional payment for care homes doing well in Care Inspectorate assessments, with penalties for poorly performing homes.

62. Between 2006 and 2015, the number of residents in older people's care homes decreased by two per cent (from 33,313 to 32,771).[50] The net cost of residential care (gross expenditure on care homes minus income) to councils has been falling. Between 2010/11 and 2014/15, the weekly residential costs to councils for each resident aged 65 or over fell by ten per cent in real terms to £372.[51]

63. The pattern of service provision has changed, with an increase in private sector provision and a fall in other sectors. Between 2006 and 2015, the change in the number of older people in residential care in each sector was:

- private sector – increased by five per cent (24,568 to 25,700)
- local authority/NHS – decreased by 23 per cent (4,876 to 3,747)
- third sector – decreased by 14 per cent (3,869 to 3,324).[52]

64. The percentage of adults in care homes who mainly pay for their own care is increasing; the percentage increased from 22 per cent of residents in 2006 to 27 per cent in 2015.[53] In 2015, the average gross weekly charge for people who paid for their own care was £708, compared with the average weekly fee for publicly funded residents of £508.[54]

Service providers want to be more involved in commissioning services

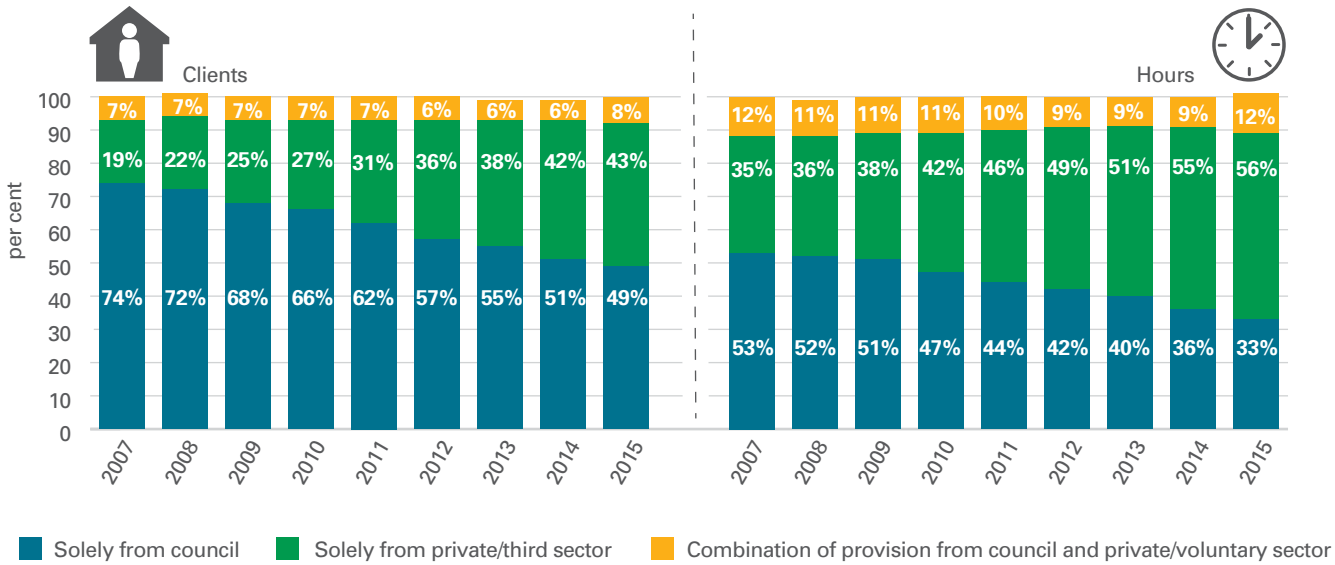
65. Commissioning social care is about how councils, NHS boards and others work together to plan and deliver services that will meet future demands and use resources, such as money, skills and equipment effectively. Jointly planned investment in home or community-based social care can save spending on unnecessary, and relatively expensive, hospital or residential care, and encourage innovation. The Christie Commission concluded that it is particularly important to:

- work closely with individuals and communities to understand their needs, maximise talents, resources, and support self-reliance, and build resilience
- recognise that effective services must be designed with and for people and communities – not delivered 'top-down' for administrative convenience
- maximise scarce resources by using all available resources from the public, private and third sectors, individuals, groups and communities.

Exhibit 10

The share of homecare provided by councils and the private/third sector, 2007 to 2015 (all ages)

Homecare provided directly by councils has fallen steadily over the past ten years.



Note: Of data limitations, the SSSC cannot provide an accurate estimate for turnover. However, they are able to calculate a 'stability index' of staff who are still in post after a year. If the index is 90 per cent it means that 10 per cent of staff present at the start of the period are no longer present. It is important to note that this does not mean that turnover is 10 per cent as the measure excludes staff who joined and left within the period under consideration.

Source: Social care services, Scotland, 2015, Scottish Government, December 2015

66. Councils have a challenging task to manage the market for providing services in their local area. There are potential tensions around making savings while ensuring high-quality services at a fair cost in an environment of increasing demand and financial pressures. There are risks to the quality of services if councils continue to drive down costs at the rate they have in the past without changing how they provide services.

67. Service providers from our focus groups who work across more than one council area found that different councils have different processes, procedures and attitudes to partnership working. They identified commissioning and procurement as common areas for improvement. In particular they felt that councils should:

- ensure they have staff with the appropriate skills for commissioning, such as financial planning and managing contracts, and be open in commissioning and contract decision-making processes. Some participants complained about unnecessary bureaucracy, noting gaps in expertise and risk appraisal and a lack of awareness of the challenges facing providers, for example the cost of employing qualified and experienced staff

- collect evidence about the effectiveness of all services (both in-house and external) and use this evidence in planning and decision-making. Councils face difficult choices, but providers felt councils sometimes protected their in-house services and workforce while cutting externally provided services, without comparing cost-effectiveness

- improve partnership working and relationships with providers. Although there were pockets of good practice, providers suggested that councils needed to work more collaboratively to provide stability to both those who provide and those who use services

- involve providers more in assessing and designing services, taking advantage of the experience and knowledge of good practice that larger providers have gained from working with councils across the UK.

68. One innovative example we identified was the Public Social Partnerships (PSP) approach used at East Renfrewshire Council (Case study 2, page 34). PSPs are strategic partnering arrangements, based on a co-planning approach. In this instance, the council worked with third-sector organisations and people who use services to share responsibility for designing services based around the needs of those who use them. Once designed, the council can then commission the service for the longer term. Several service providers in our focus groups mentioned the inclusive approach taken by East Renfrewshire Council as an example of good practice in commissioning services. It is important that councils have effective means of sharing good commissioning practice and working with practitioner groups within national organisations, such as COSLA and Social Work Scotland.

Some councils think 'out of the box', others are in a box with a very large padlock!

Service provider

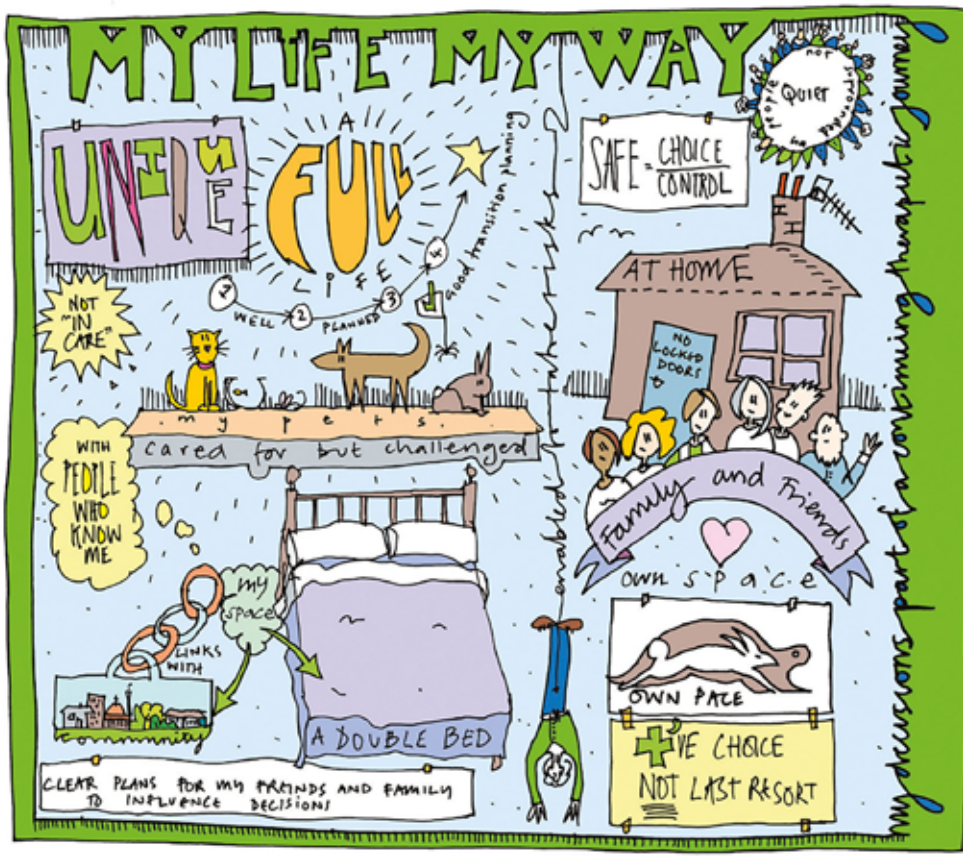
We are left out of planning discussions while having to deal with the consequences of decisions made by councils.

Provider focus group

Case study 2

East Renfrewshire Council: innovation in commissioning services

The Public Social Partnerships approach is a two-year funded programme, supported by the Scottish Government and designed to develop creative ideas for meeting the needs of people in, or about to enter, residential care. The partnership is across sectors and between people who use services. It is designed to develop thinking and support innovation. Participation in the project also helps to build resilience in people and communities by focusing on what people want rather than the services they currently receive. The illustration below describes one of the outputs from the process showing a visualisation of residential care from the point of view of someone who uses services.



Source: East Renfrewshire Council

People who use services, and carers, would value being more involved in planning how services are provided

69. The Christie Commission recognised the importance of people being involved in designing services to meet their needs. This approach is now supported by legislation such as the Community Empowerment (Scotland) Act 2015 and the Carers (Scotland) Act 2016.

70. People in our focus groups, both carers and people using services, valued the support they receive from social work services. Several said that without support they would not be able to cope or maintain employment. Feedback from our survey of 165 people indicated that the type of service provided determined whether service users felt able to influence their service delivery. For example, where service users had one-to-one support or had close relationships with staff in sheltered accommodation, they felt confident about influencing the service.

71. However, a significant number of service users felt that they had little influence over their social care provision. Some had concerns about speaking up in case the care they received was reduced or changed. Others, particularly older people, didn't want to hurt the feelings of the people providing care. While some had experience of raising issues with care providers and services being adapted accordingly, others found that no steps were taken to rectify issues. Some service users then felt care providers did not listen to them. Carers were more likely than people who use services to speak up if they were concerned about any aspects of the service delivery, but carers felt that care professionals did not treat them as partners.[55]

72. People who use social work services, and their carers, are very diverse, with differing needs. Although it is not easy to do, it is important that councils seek views and provide opportunities for involving as wide a range of people as possible in planning services or changing how they are provided. However, we found limited opportunities for people to be involved. Most of the six fieldwork councils involve representatives of both people who use services and carers in planning groups. For example, Perth and Kinross Council includes carer representatives on its multidisciplinary Carers Strategic Group. However, we found less evidence of people who use services and carers being involved more extensively in designing services.

73. Midlothian Council is one example where people who use services and carers are represented on joint planning groups, such as the Joint Older People's Planning Group that developed the Midlothian Joint Older People's Strategy 2011-15. A recent tender exercise for Care at Home in Midlothian included volunteer carers assessing all submissions, interviewing and final scoring. However, carers and people who use services generally have little involvement in commissioning or tendering, and there is scope to do more.

74. All of our fieldwork councils have a carers' strategy. All provide information for carers on their websites, including how and where to get help, which is usually through a carer assessment in the first instance. They also have partnerships with, or links to, other organisations and carers' centres in their area that provide information and support to carers. About half of the carers' centres are network partners of the national organisation Carers' Trust Scotland. Councils use various methods to collect the views of people using services, and of carers, including annual satisfaction surveys, carers' conferences and carer representatives on panels.

75. IJBs' membership must include a representative from people using services and a carer representative.[56] This is intended to ensure that carers have a role in planning and delivering of services delegated to IJBs. However, this alone is not enough to involve and consult the diverse range of people who use services and carers. Glasgow City Council has a carers' champion to represent the views of carers within the council (Case study 3, page 36).

I feel very lucky to live in [local authority]. The services for disabled people are the best in Scotland compared to other areas. [Local authority] listened to what people wanted, like supported living and individually tailored support plans.

Carer

Mental health services don't always recognise the carer input until they need them!

Carer

Everything is subject to funding therefore there is no consistency. Carers' centres need to be funded so that their services are ongoing.

Carer centre staff saved my life.

Carers

Case study 3

Glasgow City Council's Carers' Champion

Glasgow City Council's Carers' Champion represents the collective views of the city's unpaid carers within the council and speaks independently on carer issues. His role includes raising the profile of unpaid carers across the council and its wider network of agencies while also helping to develop strategies and policies that will support carers.

Glasgow has also introduced a privilege card for adult carers living in Glasgow who provide care for a Glasgow resident. It entitles them to various savings including:

- savings as part of Glasgow Life's concessionary discount scheme
- 20 per cent discount at a range of cafes in venues, such as art galleries and museums
- 20 per cent off City Parking multi-storey car parks
- discounts at certain cinemas and other commercial outlets.

In July 2015, Glasgow evaluated its Glasgow Carers Partnership, which includes Glasgow City Council, NHS Greater Glasgow and Clyde and voluntary sector organisations supporting carers within Glasgow. The council will use the resulting report and recommendations in planning and investment in carer services.

Source: Glasgow City Council

I had a procedure in hospital and I was in and out the same day, but the carer came to take me to hospital and came back at midnight to take me home. It was above and beyond.

Service user, physical disabilities

Some people we surveyed who use a homecare service were unhappy with the quality of their service

76. Between 2010/11 and 2014/15, the percentage of adults satisfied with social care or social work has fallen from 62 per cent to 51 per cent.[57] Our survey of 165 people who use services and of carers found that views on homecare dominated their discussions about the quality of care. Generally, participants with positive experiences of their current service provision highlighted some of the following factors:

- the importance of respectful and flexible carer workers
- good relationships with carer workers
- the ability to influence service delivery through self-directed support
- good timekeeping.

77. However, there were many examples of people not happy with their service experience. Common issues identified across all five local authority areas covered included:

- **Length of time a care worker spends with the person** – Most said that the care worker would be in their home for 15–20 minutes at a time. Many reported that this was not enough time to provide good quality care.

I did have [care company], and I got 15 minutes, so I had a choice between having breakfast and them running a bath for me to have on my own once they'd gone, or a shower with no breakfast.

Service user, physical disabilities

- **Timekeeping** – People who receive homecare discussed their experiences of homecare staff arriving earlier or later than expected. People we spoke to were frustrated at the homecare staff's timekeeping and poor communication.

- **Flexibility of role (undertaking tasks)** – Most people felt that the quality of care they received was affected by the limited flexibility of homecare staff in undertaking other household tasks.

- **Meals** – A large number of people receiving homecare and carers were not satisfied with the quality of the meals.

- **Trained homecare staff** – Others questioned the skills of some homecare staff. Their experience was that the homecare staff did not know how to handle them, or use equipment safely.

> **Sometimes they're late and sometimes they don't come at all.**
>
> Service user, learning disabilities

Paying care staff the Living Wage could help to reduce problems recruiting care staff, but may create other risks for providers

78. The Scottish Government's Living Wage commitment provides clear benefits for low-paid workers. However, increases in employee costs and contract costs will put pressure on councils' and service providers' finances. There are a number of risks with the current approach:

- The Scottish Government has no powers to enforce the Living Wage commitment; the UK Government reserves the power to set and enforce the legal minimum wage. The legal minimum wage across the UK is £7.20 for people aged 25 and over. The Living Wage is £8.25.

- There is a risk that providers operating across the UK may choose not to pay the Living Wage in Scotland.

- There is a risk that this could lead to unsustainable paybill increases. As well as increasing wages, National Insurance contributions and pension contributions will also rise, and service providers will need to maintain wage differentials. A recent survey of independent providers found that almost all will struggle to fund increases to £8.25 an hour. Future rises in the Living Wage may increase this pressure.

- Where councils have awarded contracts based on price before the adoption of the Living Wage, there is a risk that contractors who lost contracts, but who already pay wages at or above the living wage (and offering higher quality services) may ask councils to re-tender contracts.

> **Many people felt it was very important to have some continuity of care worker in terms of safety and building a rapport, but this was lacking. Just depressed at so many different (paid) carers coming in at all different times.**
>
> Carer

79. Applying the Living Wage also provides significant opportunities to better manage the staffing issues we describe in Part 1. Reduced staff turnover could potentially offset increased costs and provide an opportunity to improve staff skills. It could also make it easier to create a career structure for care workers and an opportunity to specialise, for example in providing services for younger people with particular disabilities, or for older people suffering from dementia.

80. Comhairle nan Eilean Siar and Perth and Kinross council felt there were particular challenges in recruiting suitably qualified staff to deliver services in isolated rural areas. In Eilean Siar, the council has set up college courses to encourage young people to view care as a worthwhile career option (Case study 4, page 38).

> **She gave me a fish pie and it was cold in the middle. She said she didn't have time to do it again, so I had to ask her to make me an omelette."**
>
> Service user, older person

Case study 4

Comhairle nan Eilean Siar: developing a stable workforce

Comhairle nan Eilean Siar faces major demographic change over the next 20 years including a projected 19 per cent decline in the working age population and a 19 per cent increase in the over 75 population. There are also a high number of single person households with no family carers available. To help arrest the decline in working age population through migration, the council has developed a project to make being a care worker a viable and attractive career for young people leaving school, as well as adults looking at career options. There are four programmes:

- Pre-Nursing Scholarship: developed to encourage people to take up a nursing career locally and part of a national initiative to increase the nursing workforce. A critical aspect of this programme is the facility to provide equitable access to learning across the Western Isles in rural and remote locations.
- Prepare to Care: This course aims to qualify and prepare students for employment, further training, or both of these, within health and social care by developing the knowledge, skills and understanding required to work in the care sector.
- Senior Phase SVQ2 Pilot: Provides flexibility in terms of work-based assessment across health and social care and equips young people to work in the community. The newly revised Social Care and Health SVQ2 is being piloted with young people in Uist and Barra by Cothrom in partnership with the council and NHS Western Isles.
- Foundation apprenticeship: Skills Development Scotland selected the council's Education and Children Services department as a pathfinder authority for the senior phase vocational pathway development in Health and Social Care.

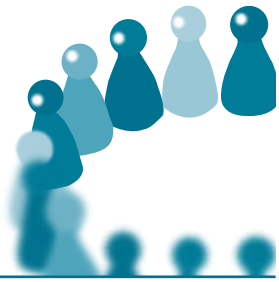
Source: Comhairle nan Eilean Siar

81. As explained in Part 1, the recruitment and retention of suitable staff is a significant problem across the care sector. Councils and providers need to work together and with the Scottish Government on long-term planning to ensure there is an effective, well-trained sustainable workforce to meet future demand. The Scottish Government has commissioned work to identify the recruitment and retention challenges facing the sector and assess whether there is a case for a national workforce-planning tool. In addition, the Scottish Social Services Council (SSSC) is working with partners to develop career pathways within social care. The first is to develop foundation apprenticeships, a vocational pathway to enable young people to experience work in the care sector and encourage care as a positive career choice.

> **The girls that came in didn't know how to use a stand aid, and they couldn't do manual lifting.**
>
> Service user, physical disabilities

Part 3

Governance and scrutiny arrangements



Key messages

1 The integration of health and social care has resulted in complex and varied governance arrangements for social work services. Elected members have important leadership and scrutiny roles, but there are risks that increased complexity could lead to members not having an overall view of social work. At a time of great change, it is essential that elected members assure themselves that the quality of social work services is being maintained and that councils are managing risks effectively. It is important that elected members receive training and guidance on the operation of the new governance arrangements and that elected members not involved in the IJB are fully informed about its operation.

2 The key role of the chief social work officer (CSWO) has changed significantly in recent years and there are risks that CSWOs may have too many roles and have insufficient status to enable them to fulfil their statutory responsibilities effectively.

3 There is scope for councils and their community planning partners to do more to promote and empower communities. This includes working with them to design, commission, deliver and evaluate services to achieve better outcomes, and to build capacity to allow communities to do more to support themselves. Elected members need to play a key role engaging with communities in a wider dialogue about council priorities.

elected members need to play a key role engaging with communities in a wider dialogue about council priorities

Social work governance and scrutiny arrangements are more complex because of health and social care integration

82. Councils' responsibilities in relation to social work are set out in the Social Work (Scotland) 1968 Act. The Act's provisions include promoting social welfare, caring for and protecting children, supervising and caring for people put on probation or released from prison and the children's hearings system.

83. Under the Public Bodies (Joint Working) (Scotland) Act 2014, councils and NHS boards are required to create integration authorities. These are responsible for the governance, planning and resourcing of adult social care services, adult primary care and community health services and some hospital services. Governance describes the structures, systems, processes, controls and behaviours by which an organisation manages its activities and performance. The Act also allows councils and NHS boards to integrate other areas of activity, such as children's health and social care services and criminal justice social work.

84. This means that councils delegate to the integration authority (IA) their responsibility for strategic planning for adult social services and for any other services they decide to include. Councils still carry the ultimate responsibility for the delivery of social work services in their area and elected members need to assure themselves that the council is meeting its statutory responsibilities.

85. IAs are responsible for planning and commissioning functions delegated from the local council and NHS board. IAs can adopt one of two main structures. All areas except the Highland Council area are following the body corporate model. Under this, they have created an Integration Joint Board (IJB) to plan and commission integrated health and social care services in their areas. Highland is following the lead agency model, NHS Highland is the lead for adult health and care services, with Highland Council the lead for children's community health and social care services. IJBs are local government bodies, as defined by Section 106 of the Local Government (Scotland) Act 1973. Councils and NHS boards delegate budgets to the IJB. The IJB decides how to use these resources to achieve the objectives of its strategic plan. The IJB then directs the council and NHS board to deliver services in line with this plan.

86. Councils have adopted various arrangements for integration. Nine councils integrated children's social work services within the IJB and 16 councils integrated social work criminal justice services.[58] The following arrangements were adopted by our fieldwork councils:

- Midlothian Council and Comhairle nan Eilean Siar include criminal justice but not children's social work services.
- East Renfrewshire Council and Glasgow City Council include both children's social work and criminal justice social work services.
- West Lothian Council and Perth and Kinross Council only include adult services.

87. The governance and scrutiny arrangements in four of our fieldwork councils (Comhairle nan Eilean Siar, Glasgow, Perth and Kinross and West Lothian) are included in Supplement 3. These illustrate the variety and complexity of arrangements now in place within councils.

88. At the time of our fieldwork, governance arrangements were still under discussion. Council chief executives were clear that accountability lies with the council for services delegated to the IJB because, under legislation, the council retains statutory responsibility for delivering social work services. But we have previously highlighted the risk that ultimate responsibility might lie with IJBs, which plan and direct councils and NHS boards in how services are to be delivered.[59] All parties need to recognise this risk and set out clearly an agreed understanding of each other's roles and responsibilities. It is essential that the chief officer of the IJB is clear about how this joint accountability will work in practice.

89. Accountability arrangements for the IJB chief officer are complex. The chief officer has a dual role. They are accountable to the IJB for the responsibilities placed on the IJB under the Act and the integration scheme. They are accountable to the council and NHS board for any operational responsibility for integrated services, as set out in the integration scheme.

90. Governance and scrutiny arrangements for IJB and non-IJB services within our fieldwork councils varied, even where the same services are included within

the IJB's remit. For example, in East Renfrewshire, scrutiny of performance happens within the IJB Audit and Performance Committee and an annual report is presented to the Council. While Comhairle nan Eilean Siar concluded that appropriate scrutiny could be provided within its existing council committee structure and that a separate mechanism for IJB functions was not required. Supplement 3 shows the variation in integration arrangements in four of our fieldwork councils. Whatever model councils choose, elected members need to assure themselves that the scrutiny arrangements are working effectively.

91. As governance and scrutiny arrangements for social work were still in transition at the time of our fieldwork visits (some changes were implemented in March 2016), it is too early to make judgements as to whether there are duplications or gaps in scrutiny. Councils indicated that they would review arrangements if they did not appear to be working effectively. Our fieldwork highlighted a number of potential risks. These include:

- the potential for an overall view of governance being lost when social work services (and budgets) are split, for example between education and children's services and the IJB
- a focus on health and adult services could restrict discussion of children's services and, in particular, criminal justice services on IJB scrutiny committees.

92. Council representation on the IJB is generally four or five senior elected members (around ten per cent of elected members), usually including the leader of the council and a senior opposition member. This means that a small subset of elected members of the council and members of the NHS board will be responsible for social work governance and scrutiny within the IJB and its committees. There is a risk that the majority of elected members could feel excluded from social work decision-making and scrutiny. There is also a risk that this arrangement leaves responsibility for governance and scrutiny with a small number of very busy elected members. Councils have set up a variety of mechanisms to ensure they keep all elected members informed. For example, Comhairle nan Eilean Siar and the IJB will hold at least two meetings a year with the wider membership of the council and NHS Western Isles.

93. It is important that elected members receive training and guidance on the operation of the new governance arrangements. The Scottish Government has produced guidance on the roles, responsibilities and membership of the Integration Joint Board.[60] COSLA is working with the Improvement Service and the Scottish Government to support elected members who do not sit on IJB boards to help them fulfil their role, including councils' ongoing statutory duties. COSLA intends to produce an elected member briefing note focusing on councils' role and interests to ensure they are kept informed of the changes. It is also hosting workshops for elected members to share their experiences. We have included an elected member's checklist as Supplement 4. Elected members may wish to use the checklist to help them consider the effectiveness of the arrangements in their council.

Health and social care integration may make strategic planning of services more difficult

94. Each IJB is required to produce a strategic plan that includes strategies for all the services delegated to it. We examined strategies for social work services in our fieldwork councils. Strategies are set out in various ways depending on the health and social care arrangements in each council. While the plans for integrated services were well developed, they are new and untested.

95. Where councils have chosen not to include services for children within their IJB, they usually continue to follow existing arrangements. For example, some align children's social work services with education, in education and children's services. In others, these services are part of an existing Health and Social Care Partnership Directorate. Strategies for services that are not within the IJB are set out in council plans such as the education and children's services plan.

96. Where criminal justice services are included within the IJB, strategies were not always as clearly set out. IJB plans generally included few references to criminal justice and some services did not have a specific criminal justice plan. Whether as part of the IJB or not, councils have, until now, worked in partnership with their Community Justice Authority (CJA) and contributed to its area and action plans. However, under The Community Justice (Scotland) Act 2016, CJAs will be abolished from 2017. Responsibility for community justice will transfer to community planning partnerships. It is important that under the new approach, strategies for criminal justice services are clearly set out as part of the IJB or community planning arrangements.

97. All the social work plans we examined demonstrate links to community planning. As members of the community planning partnerships, both IJBs and councils have signed up to local single outcome agreements (SOA) with the Scottish Government, and share the vision and priorities within these.

98. It is important that there are clear linkages between the planning of those services that are integrated and those that are not, for example the transition from children's services to adult services or between children's services and criminal justice. Planning for these transitions needs to be well coordinated to ensure a seamless service without overlaps or gaps in services, particularly where responsibility is split between the IJB and the council.

99. It is important that the scrutiny arrangements reflect the risks associated with managing transitions. Councils and elected members will need to ensure they have a strategic overview of the whole of social work service and ensure that strategy, budget arrangements, commissioning, procurement and workforce planning are coordinated at a council-wide level.

I'm happy with the services for my daughter but it was a hard fight over many years. As she moves to adult services, am I going to have to start fighting again? It worries me.

Carer

There is a risk that chief social work officers may become over-stretched

100. The Social Work (Scotland) Act 1968 requires local authorities to appoint a single chief social work officer (CSWO) who must be a qualified social worker and registered with the Scottish Social Services Council. The CSWO should demonstrate professional leadership. They have a responsibility to highlight where a council policy may endanger lives or welfare and ensure that they provide councillors and officers with professional advice in relation to social work and social care services. The CSWO should have access to the chief executive and other senior managers, councillors and social work officers. The CSWO is one of five statutory officers in councils: that is, officers that each council is required to appoint by law.[61]

101. Scottish ministers issued revised guidance on the role of the CSWO in July 2016 to reflect the introduction of health and social care integration. This summarises the minimum scope of the CSWO role, recognising the diversity of the structures and partnerships that deliver social work services. The CSWO's responsibilities apply to social work functions whether delivered by the council or

by other bodies under integration or partnership arrangements.[62] The guidance states that management and reporting structures are a matter for councils. But if the CSWO is not a full member of the corporate management team, elected members must be satisfied that the officer has appropriate access, influence and support at the most senior level. We found consensus among elected members and chief executives that it is important that the CSWOs are senior enough to carry out their responsibilities effectively. However, the CSWO's position in the hierarchy, and the arrangements to allow them to contribute to decision-making, varied between councils.

102. When the CSWO role was combined with that of Director of Social Work, the ability to influence was clear. But councils have developed executive team structures and most no longer have a Director of Social Work. At present six CSWOs are at director level and 24 are heads of service, the tier below this, with one tier-three manager in a temporary acting up role. In addition, a large proportion of CSWOs are new to the role. A survey by Glasgow Caledonian University, in November 2015, found that over half had been in post less than three years, and nine for less than a year.

103. CSWOs have strategic and professional responsibility for social work, including monitoring service quality and professional standards. Good practice indicates this should be across the full range of a council's social work functions. Scottish ministers' guidance says the CSWO must have the power and authority to provide professional advice and contribute to decision-making in the council and health and social care partnership arrangements. However, the structure of social work provision has changed over time and CSWOs do not always have operational responsibility across all functions. For example, in Midlothian, the CSWO has operational responsibility for adult services but not for services for children or older people.

104. Integration does not change the CSWO's responsibility to provide professional leadership. However, some CSWOs expressed concerns that, where children's services and/or criminal justice sit within the IJB, health issues and adult care will dominate the IJB both in terms of the agenda and in terms of personnel. They were concerned that representation of these services on the agenda would be small in comparison to adult services.

105. Reporting lines for CSWOs always lie within the council and the establishment of IJBs does not change this. However, CSWOs now have an additional statutory, non-voting place as adviser to the IJB (or the Integration Joint Monitoring Committee in Highland's lead agency model). CSWOs need to establish good, effective working relationships with their IJB chief officer. CSWOs' roles vary across all thirty-one IJBs in terms of what they are accountable for. Integration means that those CSWOs who were previously responsible for adult social care services will lose direct responsibility for their management and budget.

106. Scottish ministers' guidance indicates that the CSWO must be visible and available to any social services worker, and ensure well-grounded professional advice and guidance on practice is available. Social workers in our focus groups generally felt that their CSWO was both visible and accessible, and felt confident about consulting them.

107. The ability of CSWOs to carry out their role effectively and not become too 'stretched' across multiple functions is a potential concern. CSWOs may have

to report to one or more council committees, sit on the IJB, and attend the council corporate management team or senior management team and the IJB management team, as well as undertake day-to-day service management roles. It is important for CSWOs to achieve the trust and confidence of councils' NHS partners in order to have an influence in decision-making. CSWOs had mixed views on whether their role within the IJB would have a negative impact on their visibility or accessibility to elected members and social workers. It is too early to see how effective new arrangements will be.

108. The statutory guidance requires all CSWOs to report annually to the council and IJB on all of the statutory, governance and leadership functions of the role and delivery of the council's social work functions. This applies however they are organised or delivered. A review of CSWO annual reports in 2013 found a lack of consistency in the content and format. After consultation with relevant individuals and groups, the chief social work adviser published guidance on the content and a template for the report. The CSWO annual report gives an opportunity for the CSWO to draw together all the important strands of their work and report on them to elected members. It should provide an opportunity for the CSWO to raise their profile with elected members and, more importantly, draw their attention to any potential concerns about social work or governance issues.

109. The CSWO reports we examined from our fieldwork sites generally followed the template, but varied in the amount and level of information included. For example, Glasgow's report for 2014/15 is more concise (nine pages long with links to relevant reports and strategies), with less detail included compared with Perth and Kinross (71 pages), which contains a lot of activity information and good practice examples. CSWO reports may be considered at various meetings including full council, relevant council committees or panels or the IJB. Social work performance is regularly scrutinised through council or IJB monitoring systems and scrutiny happens through monthly, quarterly or six-monthly performance reports at appropriate committees. CSWO reports are also important in providing a high-level summary of the performance of social work functions during a particular year. It is essential that they are subject to effective scrutiny by elected members. However, we did not find evidence of detailed scrutiny of the report or challenge at these meetings.

110. The Scottish Social Services Council (SSSC) working with universities and others, has recently developed a qualification for CSWOs. The postgraduate diploma is aimed specifically at those currently in the CSWO role or who aspire to the role. There is also an option to proceed to a Masters qualification. CSWOs and social worker managers who we interviewed who are studying for this qualification all found it helpful and useful in practice, as well as helping the council in succession planning.

Elected members are key decision-makers for local social work services

111. During the era of steadily increasing council spending that ended in 2010, people's expectations were raised as to the level of service that social work services could provide. Councils are now in an era of reducing spending. Councils need to play a leading role in a wider conversation with the public about the level of social work services they can realistically provide and how they can best provide it. Current arrangements for providing care are not sustainable in the long term, given the demographic and financial pressures. As we reported in *Changing models of health and social care*: 'Services cannot continue as they are and a significant cultural shift

in the behaviour of the public is required about how they access, use and receive services'.[63] Elected members need to play a key role in this change, engaging with communities in a wider dialogue about council priorities.

112. The Christie Commission suggested that councils should work closely with individuals and communities to understand their needs, maximise talents and resources, support self-reliance, and build resilience. Communities have a significant role to play, and councils and their community planning partners should do more to encourage and help them to assume more responsibility for supporting themselves. North Lanarkshire's *Making Life Easier* service is a website that helps people to identify problems and develop their own solutions through information, professional advice and direct access to services and support (Case study 5).

Case study 5

Making Life Easier

North Lanarkshire Council worked with ADL Smartcare to develop a website to help those who wish to live independently at home. Making Life Easier provides professional advice and guidance on health issues and on managing daily living tasks. It includes hints and tips and signposts to organisations such as social and support groups, lunch clubs and drop-in cafes.

People and their carers can do an online self-assessment to identify safe and suitable equipment and minor adaptation choices that will help them manage their lives. People can choose to get the equipment and minor adaptations they need without charge through a link to the council's integrated equipment and adaptation service, or there is information on how to buy it for themselves.

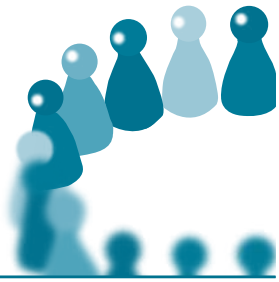
East Lothian Council is developing a similar service, which they will call HILDA – Health and Independent Living with Daily Activities.

Source: North Lanarkshire Council

113. Although health and social care integration will change the way social work services are commissioned and funded, councils remain responsible for promoting social welfare.[64] This includes improving outcomes for people who use services. Councils and IJBs need to ensure they are scrutinising budgets, plans and outcomes, including the effectiveness of services and the impact on individuals.

114. Elected members may find that their role changes, but they remain the key decision-makers for social work services on behalf of their constituents and they ensure effective scrutiny, governance and strategic oversight of the new arrangements. It is essential that elected members assure themselves of the quality of social work services and ensure councils manage risks effectively at a time of great change. With increasing financial pressures, councillors may face a difficult challenge in managing people's expectations, but they have a crucial role in doing so and providing leadership for their communities.

Endnotes



1 Social Care Services 2015, Scottish Government, December 2015.

2 Children's Social Work Statistics Scotland, 2014/15, Scottish Government, April 2016.

3 Social Care Services 2015, Scottish Government, December 2015.

4 Social Work and Social Care Statistics for Scotland: A Summary, Scottish Government, January 2016.

5 Scottish Local Government Financial Statistics, Scottish Government, February 2016.

6 Scottish Social Service Sector: Report on 2015 Workforce Data, August 2016.

7 We use the term 'third sector organisation' to describe organisations that are neither public sector nor private sector, including voluntary and community organisations (both registered charities and other organisations such as community groups), social enterprises, mutuals and co-operatives.

8 In this report, we use the word carer to mean someone who provides unpaid care. Staff who are employed to provide care are referred to as care workers.

9 *Health and social care integration*, Audit Scotland, December 2015.

10 Social Services in Scotland: a shared vision and strategy 2015 - 2020, Scottish Government,

11 National Performance Framework, Scottish Government, March 2016.

12 The Scottish Government established the independent Commission, chaired by Dr Campbell Christie CBE, in November 2010 to develop recommendations for the future delivery of public services. The Commission published its report in June 2011.

13 *Health and social care integration*, Audit Scotland, December 2015.

14 *Changing models of health and social care*, Audit Scotland, March 2016, included Scottish Government analysis of projected health and social care expenditure, provided to Audit Scotland in February 2016.

15 *Scotland's Population, The Registrar General's Annual Review of Demographic Trends 2014*, published August 2015.

16 All local authorities are responsible for maintaining a central register of all children who are the subject of an inter-agency Child Protection Plan. The register provides a system for alerting practitioners that there is professional concern about a child. Social work departments are responsible for maintaining a register of all children in their area who are subject to a Child Protection Plan.

17 Children's Social Work Statistics Scotland, 2014/15, Scottish Government, April 2016.

18 Scottish Social Service Sector: Report on 2015 Workforce Data, August 2016.

19 Experimental Statistics: Staff Retention in the Scottish Social Service Sector, SSSC, March 2016.

20 Workforce Survey of Independent Care Homes for Older People in Scotland, Scottish Care, March 2008.

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24 Mental Health (Care and Treatment) (Scotland) Act, 2003.

25 Scottish Social Services Workforce Data, Mental Health Officers (Scotland) Report 2015, August 2016.

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28 *Caring Together: The Carers Strategy for Scotland 2010 - 2015*, Scottish Government, July 2010.

29 *Valuing Carers; The rising value of carers' support*, Carers UK, 2015.

30 *An overview of local government in Scotland 2016*, Audit Scotland, March 2016.

31 The net expenditure breakdown in Exhibit 5 is taken from Scottish Local Government Financial Statistics 20014-15. The total net expenditure figure of £3.3 billion is from the audited accounts and includes pension costs and capital accounting costs that the £3.1 billion in the local financial returns (LFRs), on a funding basis, will exclude.

32 *An overview of local government in Scotland 2016*, Audit Scotland, March 2016.

33 Scottish Parliament, Health and Sport Committee, Integrated Joint Board survey responses, August 2016.

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36 *Social Services in Scotland: a shared vision and strategy 2015-2020*, Scottish Government, March 2015.

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

38 *Reshaping Care for Older People – A Programme for Change 2011–21*, Scottish Government, COSLA and NHS Scotland, 2010.

39 *Reshaping care for older people*, Audit Scotland, February 2014.

40 *Changing models of health and social care*, Audit Scotland, March 2016.

41 The NHS and Community Care Act 1990 provides a statutory framework for community care, which forms the cornerstone of community care law. It places a duty on local authorities to assess an individual's need for 'community care services'.

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

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

44 Data from Children's Social Work Statistics Scotland, 2011/12, Scottish Government, March 2013 and Children's Social Work Statistics Scotland, 2014-15, Scottish Government, June 2016.

45 *Getting it right for children in residential care,* Audit Scotland, September 2010.

46 Recreate Volunteer Programme: A social return on investment (SROI) analysis, Margaret Smith and Vikki Binnie, 2014. An SROI considers the length of time changes last to assess future value. Because this user group is often associated with a chaotic lifestyle, the study shows a range in value to reflect a conservative estimate and an estimate reflecting the sustained changes possible.

47 Local Government Benchmarking Framework, Improvement Service (website).

48 A framework agreement does not have to be a contract. However, where it is a contract it is treated like any other contract, and the EU procurement rules apply.

49 The 2016/17 fees paid to providers for local authority placements are set at £624.54 a week for nursing care and £537.79 for residential care until 30 September. After that, fees will increase to £648.92 a week for nursing care, and £558.77 for residential care until April 2017 (the £372 figure in paragraph 62 has income from contributions deducted). Fees for self-funders tend to be substantially higher.

50 Scottish Statistics on Adults Resident in Care Homes, 2006-2015, ISD Scotland, October 2015.

51 Local Government Benchmarking Framework, Improvement Service (website).

52 The Care Home Census: Scottish Statistics on Adults Resident in Care Homes 2006-2015. The census includes data on adults living in care homes in Scotland that are registered with the Care Inspectorate.

53 NHS National Services Scotland, Public Health and Intelligence, 2016.

54 These figures are for residents who do not require nursing care. The equivalent figures for residents who do require nursing care are £775 and £590.

55 The Scottish Government is holding a 'national conversation' on health and social care services. Some of the carer's quotes are taken from the Coalition of Carers in Scotland event to support carers to contribute their views, held on 25 November 2015.

56 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

57 Local Government Benchmarking Framework, the improvement service.

58 A full list of the arrangements in all councils is included in Exhibit 8, page 22 of *Health and social care integration*, Audit Scotland, December 2015.

59 *Health and social care integration*, Audit Scotland, December 2015.

60 Roles, Responsibilities and Membership of the Integration Joint Board, Scottish Government, September 2015.

61 The others are: The Head of Paid Service (chief executive) responsible to councillors for the staffing and ensuring the work of the council is co-ordinated; the Monitoring Officer prepares governance documents and advises councillors about legal issues; the Chief Financial Officer; the Chief Education Officer.

62 The Role of Chief Social Work Officer, Guidance Issued by Scottish ministers, pursuant to Section 5(1) of the Social Work (Scotland) Act 1968, Revised Version, July 2016.

63 *Changing models of health and social care*, Audit Scotland, March 2016.

64 Social Work (Scotland) 1968 Act.

Social work in Scotland

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	ISSUE	LEAD OFFICER	PDSP DATE
1	Chief Social Work Officer's Annual Report	Jane Kellock	07/12/17
	Reporting Activities of Outside Bodies –		
2	Minutes of Lothian NHS Board	Jim Forrest	Standing item
3	Minutes of West Lothian Integration Joint Board	Jim Forrest	Standing Item