Clerk and Standards Officer:
Roger Mennie
Head of Democratic and Legal Services
Dundee City Council

City Chambers
DUNDEE
DD1 3BY

19th November, 2019

TO: ALL MEMBERS, ELECTED MEMBERS AND OFFICER REPRESENTATIVES OF THE PERFORMANCE AND AUDIT COMMITTEE OF DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD
(See Distribution List attached)

Dear Sir or Madam

PERFORMANCE AND AUDIT COMMITTEE

I would like to invite you to attend a meeting of the above Committee which is to be held in Committee Room 2, 14 City Square, Dundee on Tuesday, 26th November, 2019 at 2.00 pm.

Apologies for absence should be intimated to Arlene Hay, Committee Services Officer, on telephone 01382 434818 or by e-mail arlene.hay@dundeecity.gov.uk.

Yours faithfully

DAVID W LYNCH
Chief Officer

A G E N D A

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTEREST

Members are reminded that, in terms of the Integration Joint Board's Code of Conduct, it is their responsibility to make decisions about whether to declare an interest in any item on this Agenda and whether to take part in any discussions or voting.

3 MINUTE OF PREVIOUS MEETING (Page no 1)

The minute of previous meeting of the Committee held on 24th September, 2019 is attached for approval.

4 AUDIT SCOTLAND REPORT: NHS WORKFORCE PLANNING – PART 2

(a) Presentation by Dharshi Santhakumaran, Audit Scotland

(b) Report No PAC40-2019 by the Chief Finance Officer, copy attached **(Page no 7)**

5 CLINICAL, CARE AND PROFESSIONAL GOVERNANCE (CCPG) GROUP CHAIRS ASSURANCE REPORT (Page no 49)

(Report No PAC39-2019 by the Clinical Director, copy attached).

6 FALLS PERFORMANCE REPORT (Page no 59)

(Report No PAC41-2019 by the Chief Finance Officer, copy attached).

7 GOVERNANCE ACTION PLAN PROGRESS REPORT (Page no 83)

(Report No PAC42-2019 by the Chief Finance Officer, copy attached).

8 DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT PLAN PROGRESS REPORT (Page no 99)

(Report No PAC43-2019 by the Chief Finance Officer, copy attached).

9 QUARTERLY COMPLAINTS PERFORMANCE – 2nd QUARTER 2019/20 (Page no 103)

(Report No PAC44-2019 by the Chief Finance Officer, copy attached).

10 PROGRAMME OF MEETINGS – PERFORMANCE AND AUDIT COMMITTEE – 2020

The Performance and Audit Committee is asked to agree that the Programme of Meetings of the Performance and Audit Committee be as follows:-

Date	Venue	Time
Tuesday, 11th February, 2020	Committee Room 1, 14 City Square	2.00 pm
Tuesday, 24th March, 2020	Committee Room 1, 14 City Square	2.00 pm
Tuesday, 30th June, 2020	Committee Room 1, 14 City Square	2.00 pm
Tuesday, 22nd September, 2020	Committee Room 1, 14 City Square	2.00 pm
Tuesday, 24th November, 2020	Committee Room 1, 14 City Square	2.00 pm

11 MEETINGS OF THE PERFORMANCE AND AUDIT COMMITTEE 2019 – ATTENDANCES (Page no 111)

A copy of the Attendance Return for meetings of the Integration Joint Board held to date over 2019 is attached for information and record purposes.

12 DATE OF NEXT MEETING

The next meeting of the Committee will be held in Committee Room 1, 14 City Square, Dundee on Tuesday, 11th February, 2020 at 2.00 pm.

PERFORMANCE AND AUDIT COMMITTEE
PUBLIC DISTRIBUTION LIST

(a) DISTRIBUTION – PERFORMANCE AND AUDIT COMMITTEE

(* - DENOTES VOTING MEMBER)

Role	**Recipient**
Elected Member (Chair)	Councillor Ken Lynn *
Elected Member	Bailie Helen Wright *
Non Executive Member	Jenny Alexander *
Non Executive Member	Nic Beech*
Chief Officer	David W Lynch
Chief Finance Officer	Dave Berry
Registered medical practitioner employed by the Health Board and not providing primary medical services	James Cotton
Chief Social Work Officer	Diane McCulloch
Chief Internal Auditor	Tony Gaskin
Staff Partnership Representative	Raymond Marshall
Person providing unpaid care in the area of the local authority	Martyn Sloan

(b) DISTRIBUTION – FOR INFORMATION ONLY

Organisation	**Recipient**
NHS Tayside (Chief Executive)	Chief Executive
Dundee City Council (Chief Executive)	David R Martin
Dundee City Council (Head of Democratic and Legal Services)	Roger Mennie
Dundee City Council (Members' Support)	Jayne McConnachie
Dundee City Council (Members' Support)	Dawn Clarke
Dundee City Council (Members' Support)	Fiona Barty
Dundee City Council (Members' Support)	Sharron Wright
Dundee City Council (Communications rep)	Steven Bell
Dundee Health and Social Care Partnership	Kathryn Sharp
NHS Tayside (Communications rep)	Jane Duncan
NHS Fife (Internal Audit) (Principal Auditor)	Judith Triebs
NHS (PA to Tony Gaskin)	Carolyn Martin
Audit Scotland (Senior Audit Manager)	Bruce Crosbie
Dundee University (PA to Nic Beech)	Lynsey McIrvine
Dundee City Council (Secretary to Dave Berry)	Pauline Harris

ITEM No …3……..

At a MEETING of the **PERFORMANCE AND AUDIT COMMITTEE OF THE DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** held at Dundee on 24th September, 2019.

Present:-

Members	Role
Ken LYNN (Chairperson)	Nominated by Dundee City Council (Elected Member)
Nic BEECH	Nominated by Health Board (Non Executive Member)
Helen WRIGHT	Nominated by Dundee City Council (Elected Member)
Dave BERRY	Chief Finance Officer
Tony GASKIN	Chief Internal Auditor
Diane McCULLOCH	Chief Social Work Officer
Martyn SLOAN	Person providing unpaid care in the area of the local authority

Non-members in attendance at the request of the Chief Finance Officer:-

Bruce CROSBIE	Audit Scotland
Ann Marie MACHAN	Audit Scotland
Kathryn SHARP	Health and Social Care Partnership
Lynsey WEBSTER	Health and Social Care Partnership

Councillor Ken LYNN, Chairperson, in the Chair (items I to V).
Bailie Helen WRIGHT, Chairperson, in the Chair (items VI to XVII).

I APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of:

Jenny ALEXANDER, Nominated by Heath Board (Non Executive Member)
David LYNCH, Chief Officer
Raymond MARSHALL, Staff Partnership Representative

II DECLARATION OF INTEREST

No declarations of interest were made.

III MINUTE OF PREVIOUS MEETING

The minute of meeting of the Committee held on 28th May, 2019 was submitted and approved.

IV AUDIT SCOTLAND ANNUAL REPORT AND INTEGRATION JOINT BOARD ANNUAL ACCOUNTS 2018/19

There was submitted Report No PAC34-2019 by the Chief Finance Officer presenting the Integration Joint Board's Draft Audited Annual Statement of Accounts for the year to 31st March, 2019 for approval, noting the draft external auditor's report in relation to the accounts and approving the response to the report.

The Committee:-

(i) noted the contents of the Audit Scotland cover letter that was attached as Appendix 1 and the draft external auditor's report attached as Appendix 2 including the completed action plan, and in particular that Audit Scotland had indicated they would issue an unqualified audit opinion on the Integration Joint Board's (IJB) 2018/2019 Annual Accounts;

(ii) endorsed the report as the IJB's formal response to the external auditor's report;

(iii) instructed the Chief Finance Officer to provide an update on progress of the action plan, noted in Appendix 1 of the external auditor's report, by January 2020;

(iv) approved the Audited Annual Accounts attached as Appendix 2 for signature and instructed the Chief Finance Officer to return these to the external auditor;

(v) instructed the Chief Finance Officer to arrange for the Annual Accounts to be published on the Dundee Health and Social Care Partnership website no later than 31st October, 2019;

(vi) delegated the Chief Finance Officer to consider any post balance sheet events on the actual date of signing of the accounts; and

(vii) delegated the Chief Finance Officer to ensure the ISA580 Letter of Representation is signed and submtted to the certifying auditor on the revised authorised for issue date.

The Committee further agreed:-

(viii) to note that due to the unavailability of the Chief Officer to sign the accounts by the required date of 30th September, 2019, the Integration Joint Board would fail to comply with the Local Authority Accounts (Scotland) Regulations 2014;

(ix) to note that there may be potential post balance sheet implications given the timescales between the date the Performance and Audit Committee approved the accounts for signature and the earliest date on which the accounts could be signed being 1st October, 2019;

(x) to note that the Chief Finance Officer could not sign the balance sheet and authorise the accounts for issue until the accounts were signed by the Chief Officer and the Chair of the Integration Joint Board;

(xi) that the Chief Finance Officer inform the voting members of the Committee of any post balance sheet events prior to formal signing and issue of the accounts;

(xii) to note that a change in the External Auditor's Annual Audit Report would be required and that this would be brought to the next meeting of the Committee for information.

V QUARTERLY COMPLAINTS PERFORMANCE – 1ST QUARTER 2019/20

There was submitted Report No PAC39-2019 by the Chief Finance Officer summarising for Committee the complaints performance for the Health and Social Care Partnership in the first quarter of 2019/20, and to highlight the proposed changes to improve complaints reporting for the Performance and Audit Committee. The complaints included complaints handled using the Dundee Health and Social Care Partnership Social Work Complaint Handling Procedure, the NHS Complaint Procedure and the Dundee City Integration Joint Board Complaint Handling Procedure.

The Committee:-

(i) noted the complaints handling performance for health and social work complaints set out within the report;

(ii) noted the work which had been undertaken to address outstanding complaints within the Health and Social Care Partnership; and

(iii) noted the ongoing work taking place to improve complaints handling, monitoring and reporting within the Health and Social Care Partnership.

VI CARE INSPECTORATE GRADINGS – REGISTERED CARE SERVICES FOR ADULTS (EXCLUDING CARE HOMES) 2018-2019

There was submitted Report No PAC25-2019 by the Chief Finance Officer summarising for Committee the grades awarded by the Care Inspectorate to registered care services for adults (excluding care homes), these services having a contractual arrangement with Dundee Health and Social Care Partnership, for the period 1st April, 2018 to 31st March, 2019.

The Committee:-

(i) noted the content of the report and the gradings awarded as detailed in Appendix A of the report and highlighted in section 4.2 of the report; and

(ii) noted the range of continuous improvement activities progressed during 2018-19, as described in section 4.3 of the report.

VII CARE INSPECTORATE GRADINGS – DUNDEE REGISTERED CARE HOMES FOR ADULTS 2018-2019

There was submitted Report No PAC26-2019 by the Chief Finance Officer summarising for Committee the gradings awarded by the Care Inspectorate to Dundee registered care homes for adults in Dundee for the period 1st April, 2018 to 31st March, 2019.

The Committee:-

(i) noted the content of the report and the gradings awarded as detailed in Appendix A of the report and highlighted in section 4.2 of the report; and

(ii) noted the range of continuous improvement activities progressed during 2018-19 as described in section 4.3 of the report.

VIII DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE REPORT – 2018/19 QUARTER 4

There was submitted Report No PAC30-2019 by the Chief Finance Officer updating Committee on 2018/19 Quarter 4 performance against the National Health and Wellbeing Indicators and Measuring Performance under Integration interim targets.

The Committee:-

(i) noted the content of the report;

(ii) noted the performance of Dundee Health and Social Care Partnership, at both Dundee and Local Community Planning Partnership (LCPP) Levels, against the National Health and Wellbeing Indicators as summarised in Appendix 1 and section 6 of the report; and

(iii) noted the Performance of Dundee Health and Social Care Partnership against the Measuring Performance Under Integration interim targets as summarised in Appendix 1 (table 2) and section 6 of the report.

IX DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP SUMMARY PERFORMANCE REPORT – 2019/20 QUARTER 1

There was submitted Report No PAC33-2019 by the Chief Finance Officer updating Committee on 2019/20 Quarter 1 performance against the National Health and Wellbeing Indicators and Measuring Performance under Integration interim targets.

The Committee:-

(i) noted the content of the report;

(ii) noted the performance of Dundee Health and Social Care Partnership, at both Dundee and locality levels, against the National Health and Wellbeing Indicators as summarised in Appendix 1 (tables 1, 3 and 4) and section 6 of the report; and

(iii) noted the performance of Dundee Health and Social Care Partnership against the Measuring Performance under Integration interim targets as summarised in Appendix 1 (table 2) of the report.

X DISCHARGE MANAGEMENT PERFORMANCE UPDATE ON COMPLEX AND STANDARD DELAYS

There was submitted Report No PAC37-2019 by the Chief Finance Officer updating Committee on Discharge Management performance in Dundee in relation to delays.

The Committee:-

(i) noted the current position in relation to complex delays as outlined in section 5 of the report, and in relation to standard delays as outlined in section 6 of the report;

(ii) noted the improvement actions planned to respond to areas of pressure as outlined in section 7 of the report; and

(iii) agreed to the Audit Scotland NHS workforce planning – part 2 report being discussed at the next Performance and Audit Committee.

XI DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP CLINICAL, CARE AND PROFESSIONAL GOVERNANCE

There was submitted Report No PAC27-2019 by the Chief Finance Officer updating Committee on the business of the Dundee Health and Social Care Partnership Clinical, Care and Professional Governance Group.

The Committee:-

(i) noted the exception report for the Dundee Health and Social Care Partership Clinical, Care and Professional Governance Group; and

(ii) noted that the Dundee Health and Social Care Partnership had received a report from the Drugs Commission and would provide a comprehensive response to the recommendations at a future Performance and Audit Committee meeting.

XII DUNDEE CITIZENS SURVEY 2018 – HEALTH AND SOCIAL CARE RESULTS

There was submitted Report No PAC31-2019 by the Chief Finance Officer summarising the results on the Dundee Citizens Survey 2018 that were of relevance to the Health and Social Care Partnership strategic priorities.

The Committee:-

(i) noted the content of the report and the result of the Citizens Survey 2018 as detailed in Appendix 1 and section 4.2 of the report; and

(ii) noted that the Health and Social Care results had been incorporated into the Partnership's locality needs assessment profiles that would be published on the Partnership website by 30th September, 2019.

XIII GOVERNANCE ACTION PLAN PROGRESS REPORT

There was submitted Report No PAC35-2019 by the Chief Finance Officer providing Committee with an update on the progress of the actions set out in the Governance Action Plan.

The Committee noted the progress made in relation to the actions set out in the Governance Action Plan as outlined in Appendix 1 of the report.

XIV DUNDEE INTEGRATION JOINT BOARD AUDIT PLAN 2019/20

There was submitted Report No PAC36-2019 by the Chief Finance Officer considering the proposed Dundee Integration Joint Board's 2019/20 Internal Audit Plan.

The Committee noted and approved the proposed Dundee Integration Joint Board 2019/20 Internal Audit Plan as outlined in Appendix 1 of the report.

XV DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT PLAN PROGRESS REPORT

There was submitted Report No PAC38-2019 by the Chief Finance Officer providing Committee with a progress update in relation to the current Internal Audit Plan.

The Committee noted the continuing delivery of the 2018/19 plan as well as commencement of work on the 2019/20 plan as outlined in the report.

XVI MEETING OF PERFORMANCE AND AUDIT COMMITTEE 2019 ATTENDANCES

There was submitted Agenda Note PAC23-2019 providing a copy of the attendance return for meetings of the Performance and Audit Committee held over 2019.

The Committee noted the position as outlined.

XVII DATE OF NEXT MEETING

The Committee noted that the next meeting of the Performance and Audit Committee would be held in Committee Room 1, 14 City Square on Tuesday, 26th November, 2019 at 2.00 pm.

Ken LYNN, Chairperson.

Helen WRIGHT, Chairperson.

ITEM No …4(b)……..

Dundee Health & Social Care Partnership

REPORT TO: **PERFORMANCE AND AUDIT COMMITTEE – 26 NOVEMBER 2019**

REPORT ON: **AUDIT SCOTLAND REPORT: NHS WORKFORCE PLANNING – PART 2**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC40-2019**

1.0 PURPOSE OF REPORT

The purpose of this report is to provide the Performance and Audit Committee with an overview of Audit Scotland's NHS Workforce Planning – Part 2 Report which focusses on the clinical workforce in general practice.

2.0 RECOMMENDATIONS

It is recommended that the Performance and Audit Committee (PAC):

2.1 Notes the content of Audit Scotland's NHS Workforce Planning – Part 2 report as set out in Appendix 1 to this report.

2.2 Instructs the Chief Officer to consider the findings of this report when developing the Dundee Health and Social Care Partnership's Integrated Workforce Plan prior to submission to the Integration Joint Board for approval in addition to the Primary Care Improvement Plan.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

4.1 The Auditor General published the NHS Workforce Planning – Part 2 Report "The clinical workforce in general practice" in August 2019. This report is the second of a series of audit reports on NHS workforce planning with the first report focussing on clinical staff in a hospital setting. The aim of this most recent report was to establish how effectively the Scottish Government is planning and developing the primary care workforce to meet the needs of the Scottish population. In addition to considering national planning for the primary care workforce to address current pressures on staff and patient care, it also questions how effectively workforce planning arrangements are considering the future needs of the population and what the costs of these might be. Furthermore, the report questions what impact the new General Medical Services (GMS) contract will have on the Scottish Government's ability to deliver its vision of primary care. Members of the IJB will recall that changing workforce roles are a critical element of the implementation of the Primary Care Improvement Plan, presented to the IJB at its meeting of 25June 2019 (Article XIII of the minute refers).

4.2 The key messages included in the report are noted below:

4.2.1 Expanding the primary care workforce is central to the government's 2020 vision of delivering more care at home and in the community. Primary care services face growing demand from an ageing population and an increase in the number of people with multiple chronic conditions. There are also pressures on workforce supply, including an ageing workforce and problems with recruitment and retention. The Scottish Government acknowledges these workforce pressures but has not estimated the impact they will have on primary care services.

4.2.2 The Scottish Government is working to improve primary care workforce data, but progress has been slow. There is a lack of national data on the current numbers in the workforce, workforce costs, activity and demand. This makes it difficult to plan the workforce effectively or to monitor the impact of major policy changes, such as the new General Medical Services contract.

4.2.3 The Scottish Government's commitments to train additional GPs, paramedics, nurses and midwives are on track, but it is not clear how this increase in training will translate into numbers employed in the primary care workforce. The Scottish Government has implemented a range of initiatives to improve recruitment and retention of GPs but these have had limited success to date. UK-wide pressures on the workforce and increasing demand mean the government will find it challenging to meet its GP target of an 800 (headcount) increase over ten years. Meanwhile, similar workforce pressures will make it difficult for integration authorities to increase the multidisciplinary workforce by 2021/22.

4.2.4 People are generally positive about their experiences of primary care and would be happy to receive care from professionals other than doctors in a GP practice if they understood more about their roles. However, not enough has been done to engage with the public on a national level about these changes and why they are important.

4.2.5 Progress on national workforce planning has been slow, and there has been a series of delays to planned outputs by the Scottish Government. Responsibility for planning the primary care workforce is split across different policy areas, risking duplication of work. This complexity could further slow progress because of a lack of clarity about who is responsible for making decisions.

4.3 While the majority of the recommendations are directed towards the Scottish Government to take forward, the recommendations include ensuring that the Scottish Government works with NHS Boards and Integration Authorities to model how training and recruitment numbers across all healthcare staff groups will meet estimated future demand for primary care. The IJB therefore needs to ensure that its Integrated Workforce Plan and its Primary Care Improvement plan reflect this in a local context.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment and Risk Management. There are no major issues.

6.0 RISK ASSESSMENT

Risk 1 Description	There is a risk that the IJB will not be able to recruit the workforce required within primary care to meet the needs of the population and to deliver transformation as set out within the Primary Care Improvement Plan.
Risk Category	Workforce
Inherent Risk Level	Likelihood 4 x Impact 4 = 16 (Extreme)
Mitigating Actions (including timescales and resources)	Reflection of the challenges with statements of intent to meet these within workforce plans. Work in collaboration with the Scottish Government and NHS Tayside to identify and deliver effective training and recruitment strategies
Residual Risk Level	Likelihood 3 x Impact 4 = 12 (High)
Planned Risk Level	Likelihood 3 x Impact 4 = 12 (High)
Assessment of Risk Level	Given the risk mitigation actions in place the risk is deemed to be manageable and should be accepted.

7.0 CONSULTATIONS

The Chief Officer and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

DATE: 7 November 2019

NHS workforce planning – part 2

The clinical workforce in general practice

AUDITOR GENERAL

Prepared by Audit Scotland
August 2019

Auditor General for Scotland

The Auditor General's role is to:

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- examine how public bodies spend public money
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Contents

Links

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Interactive Tableau exhibit, where further information can be viewed online

Exhibit data

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

Audit team

The core audit team consisted of: Mark Ferris, Dharshi Santhakumaran, Nichola Williams and Erin McGinley, with support from other colleagues and under the direction of Claire Sweeney.

Key facts

General practice-based multidisciplinary workforce (WTE)[1]

6,194

3,575 GPs in 2017

1,541 nurses in 2017

Investment in GP recruitment and retention since 2015/16

£15 million

over 1 in 3

GPs are aged 50 or over

Funding paid to GP practices in 2017/18

£794 million

over half

Nurses employed by GP practices are aged 50 or over

Notes:
1. Based on survey data.

Summary

Key messages

1 Expanding the primary care workforce is central to the government's 2020 vision of delivering more care at home and in the community. Primary care services face growing demand from an ageing population and an increase in the number of people with multiple chronic conditions. There are also pressures on workforce supply, including an ageing workforce and problems with recruitment and retention. The Scottish Government acknowledges these workforce pressures but has not estimated the impact they will have on primary care services.

2 The Scottish Government is working to improve primary care workforce data, but progress has been slow. There is a lack of national data on the current numbers in the workforce, workforce costs, activity and demand. This makes it difficult to plan the workforce effectively or to monitor the impact of major policy changes, such as the new General Medical Services contract.

3 The Scottish Government's commitments to train additional GPs, paramedics, nurses and midwives are on track, but it is not clear how this increase in training will translate into numbers employed in the primary care workforce. The Scottish Government has implemented a range of initiatives to improve recruitment and retention of GPs but these have had limited success to date. UK-wide pressures on the workforce and increasing demand mean the government will find it challenging to meet its GP target of an 800 (headcount) increase over ten years. Meanwhile, similar workforce pressures will make it difficult for integration authorities to increase the multidisciplinary workforce by 2021/22.

4 People are generally positive about their experiences of primary care and would be happy to receive care from professionals other than doctors in a GP practice if they understood more about their roles. However, not enough has been done to engage with the public on a national level about these changes and why they are important.

5 Progress on national workforce planning has been slow, and there has been a series of delays to planned outputs by the Scottish Government. Responsibility for planning the primary care workforce is split across different policy areas, risking duplication of work. This complexity could further slow progress because of a lack of clarity about who is responsible for making decisions.

Recommendations

The Scottish Government should:

- undertake scenario planning to identify the potential impact of workforce pressures on all staff groups and set out how it plans to address these. This should make use of the NHS Education for Scotland (NES) data platform and include analysis of vacancy rates and the demographics of the workforce
- work with NHS boards and integration authorities to model how training and recruitment numbers across all healthcare staff groups will meet estimated future demand for primary care
- provide a clear breakdown of the costs of meeting projected demand through additional training and recruitment across all healthcare staff groups
- implement plans to collect data from GP practices on workforce numbers, activity, income and expenses. Whole time equivalent (WTE) as well as headcount data should be collected on workforce numbers. This data should be used to:
  - better understand the current workforce
  - underpin workforce planning
  - monitor progress against commitments
- collect data on the impact of workforce pressures on staff in primary care and set out how any issues will be addressed. This should include:
  - workload
  - sickness absence levels
  - staff morale
  - intention to leave the workforce
- work with primary care professionals to develop a coordinated national approach to engaging with the public about the changes to how primary care services are delivered
- monitor the impact of the GMS contract, including:
  - progress towards achieving the aim of changing the role of the GP and reducing GP workload
  - impact on rural and deprived areas
  - impact on staffing of out-of-hours services
  - impact on staff
  - impact on patients, including quality and continuity of care
- monitor progress towards meeting workforce commitments, including identifying the barriers to meeting the commitments and putting plans in place to meet demand if they are not achieved
- implement plans to simplify the workforce planning governance structure and clearly identify roles and responsibilities both nationally and locally.

Background

1. The Scottish Government's long-term vision for health and social care is to shift the balance of care so that there is a greater focus on keeping people well in their own homes and the community. This vision is set out in a range of policy documents and plans, going back to 2005, and is central to the government's 2020 Vision, published in 2011 (Exhibit 1, page 8). Primary care plays a major role in achieving this vision, as primary care professionals can identify issues early and support people to manage their own health as far as possible.

2. The Scottish Government intends to support the shift in the balance of care by increasing funding for primary care. In *Health and Social Care: medium term financial framework,* it committed to increasing primary care funding by £500 million over five years, so that, by 2021, 11 per cent of the frontline NHS Scotland budget should be spent on primary care.[1] The financial framework did not set out how the Scottish Government defines primary care spending, or what proportion of this increase will be spent on the workforce.

3. As well as increasing funding for primary care, the Scottish Government also aims to change the way primary care services are delivered. It plans to expand the primary care workforce, so that care will be provided by a range of professionals working together in multidisciplinary teams (MDTs). The Scottish Government wants people to receive care from the most appropriate member of the MDT. The size and make-up of these MDTs will vary according to local need, but MDTs may include nurses, advanced nurse practitioners (ANPs), physiotherapists, pharmacists and paramedics. MDTs may also include non-clinical staff, such as community link workers, who can support patients to access wider services.

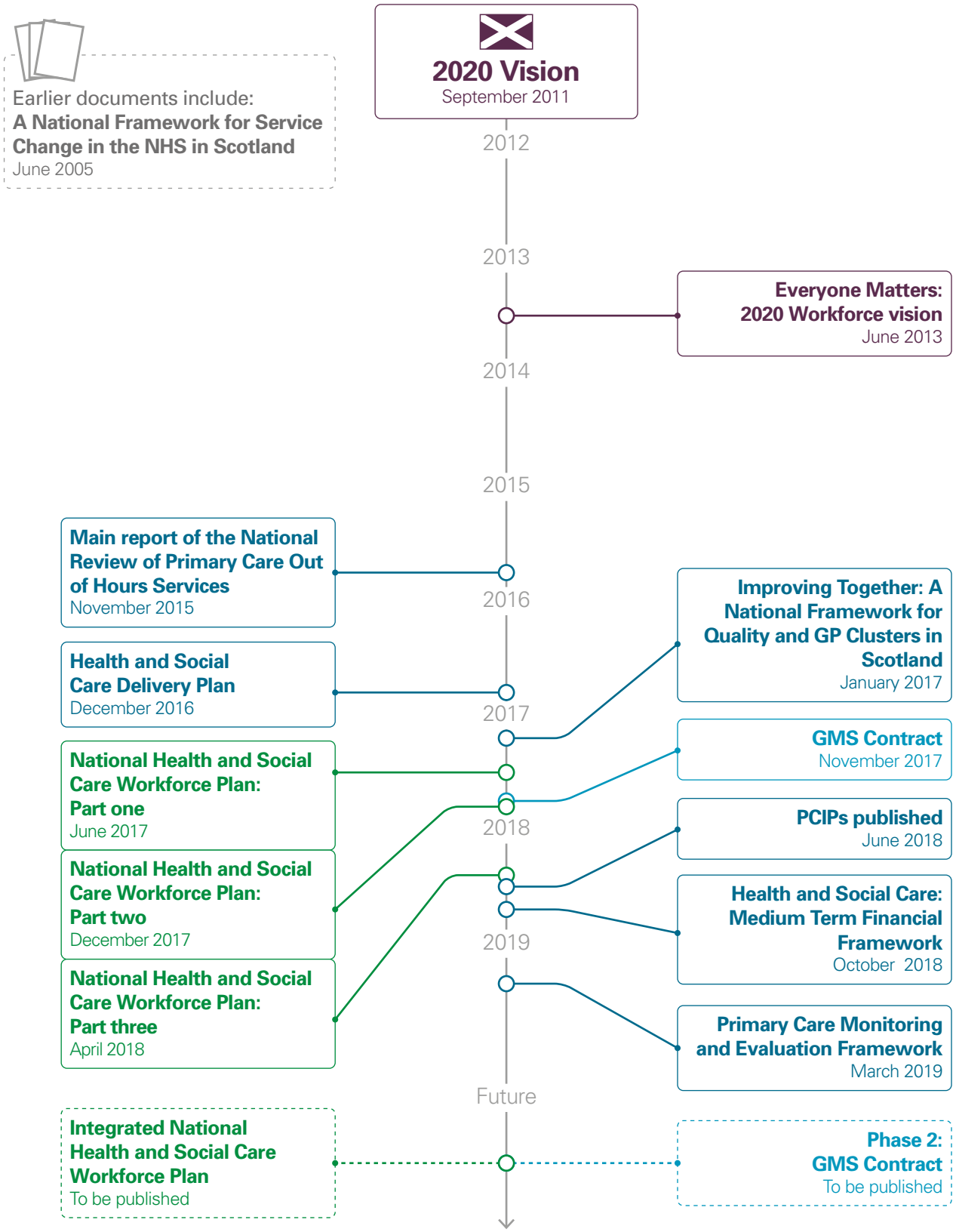
4. MDTs may be based in individual GP practices or work across a cluster of practices. These teams are the focus of this audit, but they do not work in isolation. To carry out their role, they need to work closely with other primary care professionals, for example, district nurses and the wider community nursing team, and colleagues working in hospitals and in social care. Any changes to the way that professionals work in the MDT has an impact on those working in the rest of the system. The Primary Care Clinical Professions Group have set out a joint statement on their vision for the future of primary care, and how the different professions will work together, based on 21 principles.[2]

5. Reform of primary care is complex and challenging. It is not solely the responsibility of the Scottish Government; NHS boards and integration authorities (IAs), which are partnerships between NHS boards and councils, have a crucial role. The voluntary sector also has a role to play, particularly in the development of the community link worker workforce. Locally, IAs are responsible for planning and resourcing primary care services. As the multidisciplinary workforce grows, the aim is that members of MDTs will be employed by NHS boards rather than GP practices. In the longer term, NHS boards will also take on more responsibility for owning practice premises.

Exhibit 1

Policy timeline

The Scottish Government's vision to shift the balance of care has been in place since 2011.



Note: PCIPs – primary care improvement plans, produced by integration authorities.

Source: Audit Scotland

6. These changes to primary care will require effective national and local workforce planning to make sure the right workforce is in place to meet the needs of Scotland's population. In our 2013 report, *Scotland's public sector workforce*, we define workforce planning as 'the process that organisations use to make sure they have the right people with the right skills in the right place at the right time'. For primary care, this means that the Scottish Government, NHS boards and IAs have to understand the needs of the population, both now and in the future, and plan the workforce to meet demand. We have previously highlighted the risk that the NHS workforce is being planned in response to budget pressures rather than strategic needs.[3]

7. Primary care is usually a person's first point of contact with the NHS. It is provided in the community by generalist health professionals, and includes general practice, community pharmacy, dentistry and optometry services. It covers both physical and mental health, and all age groups and health conditions.

8. Most GPs are self-employed. GP partners are GPs who own and run practices, usually in partnership. Historically, they have been responsible for employing their own staff, including other salaried GPs. Practices are contracted by NHS boards to provide primary care services.

9. Data on the size and make-up of the primary care workforce is limited (paragraphs 57–58), so workforce estimates are based on available survey data (Exhibit 2, page 10).

10. In April 2018, the new General Medical Services (GMS) contract came into effect. This contract aims to:

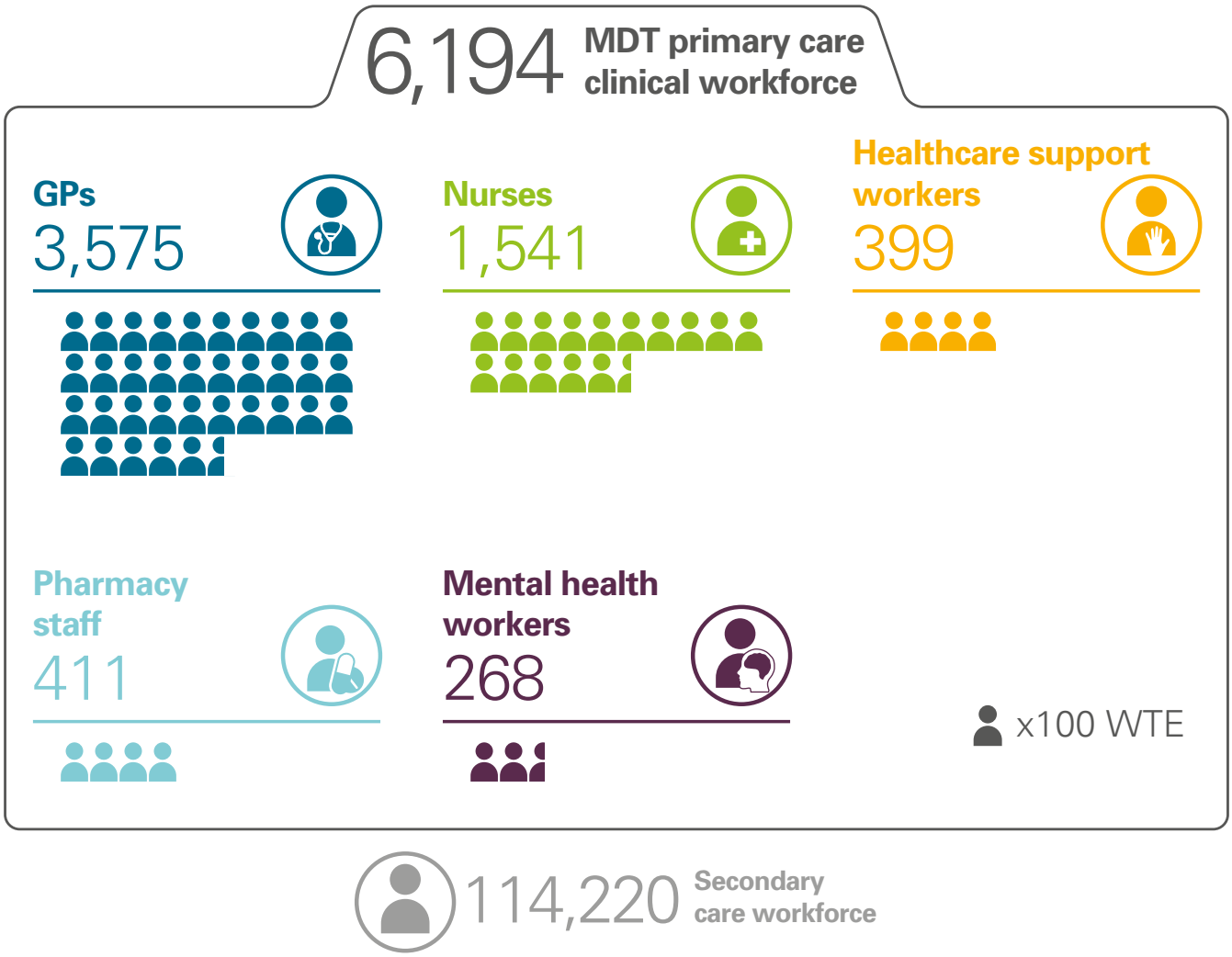
- refocus the role of GPs as expert medical generalists
- reduce GP workload and allow them to concentrate on patients with more complex care needs
- provide better care and improved access for patients
- improve infrastructure and reduce risk.

11. The contract is accompanied by a memorandum of understanding (MOU), which sets out the role of the GP as the senior clinical decision-maker at the head of the MDT. The increased role of other professional groups in the practice is intended to free up GP time and make it easier for patients to access the most appropriate care. The MOU also sets out priorities for reform to support the implementation of Phase 1 of the contract, from 1 April 2018 to 31 March 2021. As part of the contract, all IAs were required to work with NHS boards and GPs to develop primary care improvement plans (PCIPs). These plans should explain how the priorities set out in the MOU will be implemented locally. More information on the background and aims of the GMS contract is provided in our *General Medical Services contract in Scotland: a short guide*.[4]

Exhibit 2

The multidisciplinary primary care workforce in Scotland

A number of professional groups make up the MDTs based in GP practices.



Notes:

1. Figures given are whole time equivalent.
2. The figures for GPs, nurses and healthcare support workers are estimates made as part of the 2017 National Primary Care Workforce Survey carried out by ISD Scotland. These figures will only include staff members employed by the GP practice. Allied health professional data is not available.
3. The secondary care WTE figure excludes administrative staff and may include some staff employed by the NHS board but working in a GP practice, as it is not possible to separately identify these staff members.

Sources: Secondary care, ISD Scotland workforce trend data for March 2017 (2017 data used to be consistent with the latest primary care workforce survey); Pharmacy staff data provided by the Scottish Government, as at March 2019; Mental health workers, Mental health worker quarterly performance report, as at July 2019 (2019 data used for pharmacists and mental health workers, as 2017 data not available); Other staff groups, ISD Scotland National Primary Care Workforce Survey 2017.

About this audit

12. In July 2017, the Auditor General published the first in a series of audit reports on NHS workforce planning.[5] That report focused on clinical staff in a hospital setting and concluded that:

- the Scottish Government and NHS boards had not planned effectively for the long term
- responsibility for NHS workforce planning was confused
- there was a risk of further fragmentation as health and social care planning and planning for specialist medical centres developed.

It found that NHS staff were raising concerns about workload, and that NHS services were under increasing pressure. The Scottish Government expects demand for health and social care to increase but is yet to provide a clear analysis of the skills and workforce numbers needed to meet this demand. A summary of progress against the recommendations made in the first report is set out in Appendix 1 (page 33).

13. The aim of this audit was to establish how effectively the Scottish Government is planning and developing the primary care clinical workforce to meet the needs of the Scottish population. We set out to answer four key questions:

- How effectively is national workforce planning for the primary care clinical workforce addressing current pressures on staff and patient care?
- How well are national primary care clinical workforce planning arrangements considering the future needs of the Scottish population?
- What are the anticipated workforce costs to meet demand for primary care services and how effectively are these being planned for?
- What impact will the new GMS contract have on the Scottish Government's ability to deliver its vision of primary care?

14. This audit looked mainly at the national approach to workforce planning and how well it supports planning at regional and local levels. It focused on the general practice-based workforce of GPs and the wider clinical MDT, including nurses, allied health professionals (AHPs), pharmacists and others, as they are central to the implementation of the new GMS contract. AHP is a term which covers a range of healthcare professionals including paramedics, physiotherapists, occupational therapists and podiatrists. For the purposes of this report, when we refer to the primary care workforce, we mean the general practice-based clinical workforce. Although the dentistry, optometry, community nursing and care home workforce fell outwith the scope of this audit, they are an important part of the overall primary care workforce, and many of the issues highlighted in this report are also relevant to planning for the wider workforce.

15. This report is in two parts:

- Part 1 examines current pressures on the primary care workforce.
- Part 2 focuses on planning the future workforce to meet the needs of the Scottish population.

Part 1

The primary care landscape

There are significant pressures facing the primary care workforce

Demographic issues put increasing pressure on primary care services

16. Scotland's population is ageing. People aged over 75 are projected to be the fastest-growing age group in Scotland, expected to grow by 27 per cent between 2016 and 2026. The average number of patients registered at a GP practice is increasing. Between 2013 and 2018, the average practice list size across Scotland increased by eight per cent, from 5,602 to 6,073 patients.[6] Scotland's ageing population means that more people will be living longer with multiple long-term conditions, putting increasing pressure on the NHS.[7] This places pressure on general practice as GPs manage growing numbers of patients with multiple and complex health needs.

17. There are significant health inequalities across Scotland. People living in the most deprived areas have a lower life expectancy than those living in more affluent areas. They are also likely to spend more years living with ill health. From 2015 to 2017, the difference in healthy life expectancy between the ten per cent most deprived and ten per cent least deprived areas was 22.5 years for males and 23 years for females.[8] Primary care services in deprived areas face particular issues in meeting the complex needs of their patients, who are more likely to have multiple chronic conditions linked with poverty.

Recruitment and retention issues create pressures on the workforce

18. Recruitment and retention difficulties are one of the key issues facing the primary care workforce (Exhibit 3, page 13). Although there has been a slight increase in the overall headcount of GPs, the number of GPs who are partners has decreased, from 3,721 in 2013 to 3,396 in 2018. The number of practices being taken over by NHS boards has been rising.[9] This means that the practice is run by the NHS board instead of by GP partners as independent contractors, often because of difficulties recruiting new partners or retaining existing ones. The Royal College of General Practitioners (RCGP) Scotland recently reported that 26 per cent of GPs think they are unlikely to be working in general practice in five years' time.[10]

19. Until 2017, the main source of data on staff and vacancies in GP practices was a primary care workforce survey, run by ISD Scotland, on behalf of the Scottish Government. This was completed by GP practices and run every two years. The survey was voluntary and had a response rate of 82 per cent in 2017, up from 58 per cent in the previous survey, run in 2015. Fifty-nine per cent of GP vacancies that occurred in 2017 were filled, but 27 per cent of those took more than six months to fill. Commonly reported challenges in filling GP vacancies in 2017 included a shortage of applicants and the fact that the practice was in a rural area. The most commonly reported reasons for difficulty in filling nursing positions were a lack of candidates and the quality of the candidates applying.

Exhibit 3

Pressures on the primary care workforce

The available data shows workforce numbers increasing, but there is wide variation in vacancy rates across the country.

Workforce in post

4,994 GPs in 2018
Up 2.4% since 2013

3,575 WTE GPs in 2017
Down 4.3% since 2013

2,297 Nurses in 2018
Up 8.1% since 2013

1,541 WTE Nurses in 2017
Up 8.5% since 2013

Absences

Practices that said they often could not fill absences, 2017

	Planned absence	Unplanned absence
GP	1/5	1/2
Nurse	1/10	1/4

Age of workforce

(50 years or over in 2017)

Over 1 in 3 GPs

50+

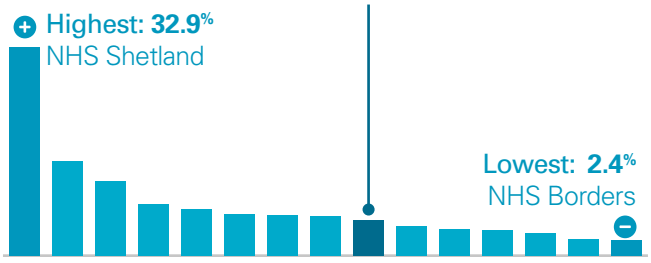
Over half of nurses employed by GP practices

Vacancies

5.6% vacancy rate for GPs across Scotland

Highest: **32.9%** NHS Shetland

Lowest: **2.4%** NHS Borders



2.4% vacancy rate for nurses in GP practices across Scotland

Highest: **4.7%** NHS Lanarkshire

Lowest: **0%** NHS Borders, Orkney, Shetland and Western Isles

1 in 4 practices reported a GP vacancy in 2017

Interactive data available on our website

Notes:
1. The GP total includes 564 third-year trainees in 2018 and 490 third-year trainees in 2013. The figure for nurses includes only those employed by a GP practice, and not those employed by an NHS board.
2. WTE – Whole-time equivalent.
3. Trend data not used for vacancies and age of workforce, as these figures are based on a survey with large differences in response rates between years.
4. This level of detail is only available for GPs and nurses.

Source: Audit Scotland using ISD Scotland data

20. Out-of-hours services are a fundamental part of the health system, providing primary care services outwith GP practice opening times. Pressures on the primary care workforce are also reflected in the delivery of out-of-hours services. NHS boards completed the part of the primary care workforce survey that asked about out-of-hours care. Boards reported that 90 per cent of out-of-hours shifts were filled but noted the amount of effort this took. The most commonly reported actions taken to fill shifts were the use of financial incentives such as increased rates and staff working longer shifts. Other issues reported included:

- instances of both nurses covering GPs' shifts and GPs covering nurses' shifts
- out-of-hours services being delivered through NHS 24 and a hospital ward because of difficulties in filling shifts
- a reduction in the number of locations where out-of-hours services were provided.[11]

The primary care workforce is changing

21. The primary care workforce survey data is used to estimate the whole-time equivalent (WTE) GP workforce across the country. The data shows a fall in the WTE GP workforce from 3,645 in 2015 to 3,575 in 2017. This suggests that, although the overall number of GPs may be increasing, more are choosing not to work full-time. A GP session is about five hours, and one WTE represents eight sessions a week. The demographics and changing working patterns of the primary care workforce pose a challenge to future supply:

- A higher proportion of GPs aged between 50 and 59 are working eight or more sessions a week.
- Those aged 25-49 years are more likely to be working four to seven sessions a week.
- Partners are often working more sessions a week than salaried GPs.

The increase in the proportion of GPs who are salaried rather than partners, and the pattern of younger GPs increasingly working part-time, is likely to mean that for every GP that retires more than one will need to be trained and recruited to replace them.

22. Recent changes to pension and tax arrangements may have an impact on GP recruitment and retention. The British Medical Association (BMA) has raised concerns that limits on annual and lifetime allowances, which govern how much GPs can contribute to their pension funds before incurring a tax charge, will lead to GPs retiring early or reducing their workloads. The BMA has also expressed concerns about the impact of UK Government changes to increase employer pension contributions by six percentage points, from 14.9 per cent to 20.9 per cent, from April 2019. The UK Government has committed to provide funding to cover some of the cost of increased pension contributions to the NHS. In June 2019, the Scottish Government confirmed that it would provide additional funding to cover the remaining £48.4 million for 2019/20.

23. The Scottish Government has identified EU withdrawal as having a major impact on the health and social care workforce, but it has not set out potential scenarios or how it plans to respond. Although data on the nationality of doctors

is available only for those who took up a licence to practice in the UK from June 2017, the General Medical Council (GMC) holds data on country of qualification for all doctors. This data shows that, in 2018, 3.7 per cent of Scottish GPs had graduated in a European Economic Area (EEA) member country. Remote and rural areas of Scotland, including Argyll and Bute, Orkney, Shetland and the Western Isles are more reliant than other areas on non-UK-licensed doctors.[12] The GMC has looked at the relationship between where medical students qualified and their nationality. It concluded that using place of qualification as a proxy for nationality is likely to result in an underestimate of the number of doctors who were EU nationals working in the UK.[13]

24. As at March 2018, five per cent of nurses and midwives in the UK had first registered in the EEA. Between 2016/17 and 2017/18, there was a drop of 87 per cent in the number of EEA-qualified nurses and midwives joining the UK register, and an increase of 29 per cent in those leaving it.[14] This suggests that EU withdrawal will exacerbate existing workforce pressures.

The Scottish Government does not collect enough information on the impact that primary care workforce pressures are having on staff

25. There is a lack of data on the impact of workload pressures on staff in primary care. The Scottish Government's national staff survey is completed only by staff employed by NHS boards, and not those employed by GP practices, or most GPs themselves.

26. The GMC runs an annual survey of trainees and their trainers, including those in general practice, which includes questions about workloads.[15] Those delivering training were more likely to report a heavy or very heavy workload than those training in other specialties, 78 per cent compared with an average of 59 per cent across all other specialties. They were also more likely to work beyond normal working hours, with 59 per cent doing so daily. Among doctors in GP training posts, although overall satisfaction was high, responses to questions on workload indicate this is an area of concern. Thirty-five per cent rated their workload during the day as heavy or very heavy, and 46 per cent were working beyond scheduled hours at least weekly.

27. A recent RCGP survey of Scottish GPs found that 37 per cent feel so overwhelmed by their daily tasks that they cannot cope at least once a week. Workload pressures may have an impact on patient experience as well as staff morale; 35 per cent said that their stress levels have an impact on their ability to make decisions.[16]

28. Without national data on, for example, staff morale or sickness absence levels for all staff groups, the Scottish Government cannot identify and monitor the impact that workload pressures may be having on the primary care workforce. When making major changes to the workforce, the Scottish Government needs to understand the challenges facing the workforce and monitor the impact of policy changes on the people delivering those changes.

Patients are generally happy with the quality of care from their GP practice

29. The Scottish Government carries out a health and care experience survey every two years. This asks the public about their experience of health and care services; it covers GP practices and out-of-hours care. The latest survey, in 2017/18, reported a mixed picture regarding patient experience. There is a national target that 90 per cent of people should be able to access a GP, or an

appropriate healthcare professional, within 48 hours if they need to. The survey found that this target was met, with 93 per cent of people able to see a GP within two days. All NHS boards, and all except two IAs, met this target. North Lanarkshire and Aberdeenshire each missed it by one percentage point.

30. Although the responses to some questions in the survey indicated a decline in patient satisfaction, satisfaction remains high overall (Exhibit 4, page 17). Eighty-three per cent of people rated the overall care provided by their GP practice as good or excellent in 2017/18, a slight fall from 87 per cent in 2011/12.

31. When asked about recent experiences with a health professional at their GP practice, 93 per cent of people were positive about feeling listened to and 95 per cent understood the information they had been given. However, there was a lower percentage of positive responses when people were asked if they felt their treatment had been well coordinated (78 per cent) and if they knew the health professional well (50 per cent).

More engagement with the public is needed on changes to primary care

32. The Scottish Government's vision for primary care represents a significant change to how services will be delivered. It intends to expand GP-led MDTs to enable people to receive care from the most appropriate member of the MDT (Case study 1, page 18). The various professional groups believe a national campaign is needed to ensure that members of the public understand why they may be asked more questions than before when they want to make an appointment, and why they will not necessarily see a GP. We have previously reported on the need for greater public engagement by the Scottish Government, NHS boards and IAs to build support for change by increasing understanding.[17] Following discussions between the primary care professions and the Cabinet Secretary for Health and Sport, the Scottish Government is currently developing its approach to public engagement on this issue.

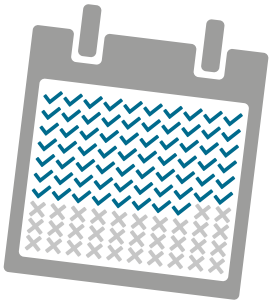
33. Some public engagement has suggested that people may be happy to see other staff members within a GP practice when they understand more about the roles of these staff members and are confident in the quality of care. A survey was carried out by Our Voice Citizens' Panel to ask people about primary healthcare and their views on seeing non-GP medical professionals.[18] Seventy-eight per cent of respondents said that they would consider going directly to non-GP healthcare professionals if they were happy with the treatment that they had received from them previously. Three-quarters would be more likely to accept an appointment with a health or social care professional who was not a GP if they understood more about their role.[19]

34. The Scottish Government commissioned a study on pharmacists working in GP practices, carried out through surveys and interviews with patients and the other members of the MDTs in the practices. Both the patients and the teams had positive feedback about the quality of the care, and the knowledge and ability of the pharmacists. Eighty-four per cent of patients surveyed said that they were confident that the pharmacist would prescribe as safely as a GP and 83 per cent said that they were more interested in the quality of the care they received than in who delivered it. However, 43 per cent still said that, given the choice, they would prefer to see a GP rather than a pharmacist.[20]

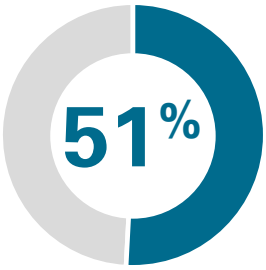
Exhibit 4

Health and care experience survey

The results of the survey show that patients are mostly satisfied with their care, although in some areas there has been a drop in satisfaction.



68%
able to book an appointment in advance
(by at least 3 days)
Down from 80% in 2011/12



people able to speak to a doctor or nurse on the same day, when required
Up from 45% in 2011/12

83%
said their overall care was good or excellent
Down from 87% in 2011/12

83%
who used out-of-hours care rated the quality of care as good or excellent

87%
found it easy or very easy to contact their GP in the way that they want

67%
happy with the arrangements for seeing a GP
Down from 75% in 2011/12

70%
happy with the arrangements for seeing a medical professional

Note: Trend data not available for all questions.

Source: Audit Scotland using the Scottish Government's health and care experience survey

Case study 1

Musculoskeletal (MSK) physiotherapists

MSK conditions are estimated to account for about one in five GP appointments, and are the second biggest cause of sickness absence in the UK. MSK advanced practitioner physiotherapists as a first point of contact in primary care MDTs have the potential to:

- improve access for patients
- support greater self-management
- reduce GP workload
- reduce referrals to orthopaedic specialists.

Several areas around Scotland have introduced MSK physiotherapist pilots to show the impact that this can have on general practice. For example:

Nov 2015

NHS Forth Valley recruited 2.4 WTE MSK advanced practitioner physiotherapists to work across two GP practices.

Over the first two years, 8,417 patients accessed the service, with 60 per cent of people able to self-manage following the appointment. Orthopaedic referrals decreased across both practices by approximately 212 referrals a year.

Jun 2016

Inverclyde appointed an MSK advanced practitioner physiotherapist (0.88 WTE) to work across three GP practices.

The pilot concluded in June 2017. During the pilot, the physiotherapist saw 55 per cent of MSK consultations across the three practices and 56 per cent of referrals were made directly by receptionists to the physiotherapist. It was reported that the proportion of consultations where people needed to be prescribed medication decreased from 80 per cent to 20 per cent for patients presenting with an MSK problem. The evaluation highlighted the need for better routine data collection to enable monitoring of the impact on GP time and on referrals to secondary care services.

Source: Audit Scotland using *Evaluation of New Models of Primary Care: Inverclyde Case Study*, Scottish School of Primary Care, January 2018 and information provided by NHS Forth Valley

The new GMS contract will affect the primary care workforce

The new GMS contract is accompanied by a new funding formula that may affect rural areas

35. The new contract is accompanied by a new funding formula for GP practices. The aim of the new formula is to better reflect the workload of GPs. The practices that stand to lose funding because of this new formula have received a guarantee from the Scottish Government that their funding will be protected. Some rural GPs

have expressed concerns that the formula will have a disproportionate impact on rural GP practices, as under the new workload calculation they are less likely to receive an increase in funding than urban practices.

36. Under the previous formula, rural practices received more funding per patient than practices in urban areas, an average of £264.1 per patient in the most rural areas in 2017/18, compared with £101.2 per patient in the most urban areas.[21] Although funding has been protected so that no practice will see its funding drop, difficulties in recruiting and retaining staff may increase when these practices have to compete for staff with practices with increased funding. This could also have an impact on the morale of staff. These concerns have been raised in response to a petition to the Scottish Parliament on medical care in rural areas.[22]

37. The Rural GP Association of Scotland carried out a survey with a small sample of 66 rural GPs on the new contract, in March 2018. Sixty-eight per cent felt less confident that the changes would benefit rural practices and about 70 per cent felt less confident about the sustainability of their practice. Concerns were specifically expressed about the funding formula, recruitment and retention issues, and out-of-hours service delivery.

The Scottish Government should do more to measure the impact of the GMS contract on patients and staff

38. The Scottish Government carried out an equality impact assessment on the GMS contract, in which it considered the impact that the contract could have on specific groups, including certain age groups, different genders and those from deprived areas and rural areas.[23] The GP contract impact assessment split this into:

- the impact on GPs
- the impact on the rest of the primary care team
- the impact on patients.

39. The impact assessment does not fully consider the concerns expressed about some aspects of the new contract. For example, the assessment concludes that there will be a positive impact on rural practices because protected funding mitigates the potential negative impact of the funding formula. As the impact assessment does not fully acknowledge potential risks it does not set out how any negative impact could be monitored, or concerns addressed.

40. The Scottish Government published a primary care monitoring and evaluation strategy in March 2019.[24] This includes indicators on the size of the workforce and involves the use of the health and care experience survey to measure patients' views. There are no measures that would allow the Scottish Government to monitor the direct impact of the GMS contract, including the intended effects on the role of the GP, recruitment and retention, and any impact on staff or patient care. The Scottish Government is due to publish an evaluation work plan to provide more detail on how it will monitor the priority areas set out in the strategy. Health Scotland is also due to produce a report on primary care in Scotland later in 2019, which is planned to include data across a wider range of indicators.

Part 2

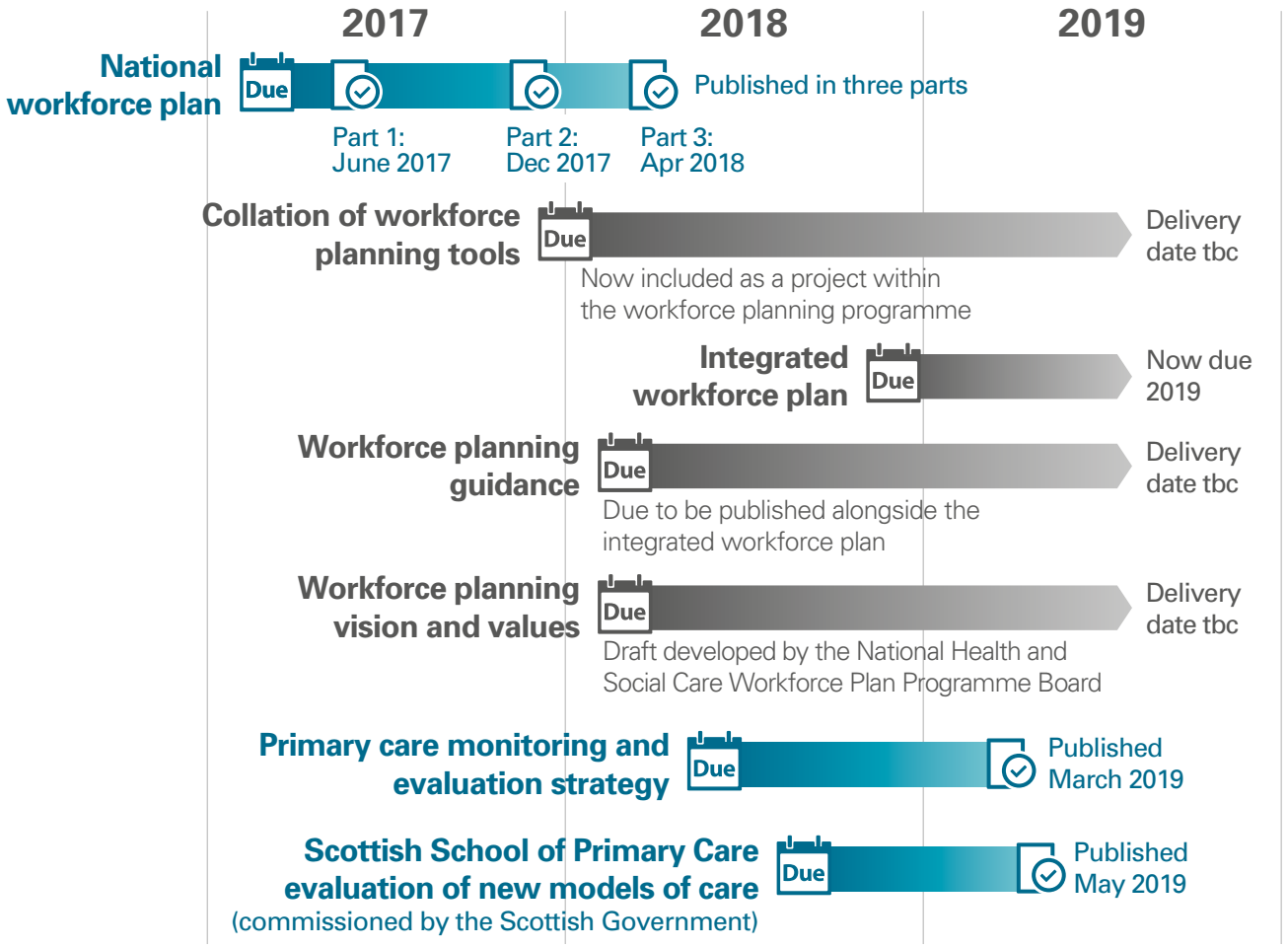
Planning the future workforce

The Scottish Government is developing its approach to workforce planning but progress has been slow

41. The Scottish Government initially planned to publish a national workforce plan in spring 2017, covering the entire health and social care workforce. It then revised its approach, publishing the plan in three parts, covering the NHS workforce, the social care workforce and the primary care workforce. This was to be followed by an integrated national health and social care workforce plan, a joint publication with the Convention of Scottish Local Authorities (COSLA), in 2018. This is now due to be published in 2019 (Exhibit 5).

Exhibit 5

Workforce planning and primary care outputs have been delayed



Source: Audit Scotland

42. The third part of the plan, published in April 2018, considers how primary care workforce arrangements will change.[25] The plan sets out the intention to reform primary care in Scotland by building and expanding primary care MDTs. The plan recognises the challenges facing primary care, including that demand for primary care services is increasing, because of the ageing population and a rise in people suffering from two or more chronic conditions. It also notes the pressures arising from an ageing workforce, but it does not include projections of what this might mean in terms of numbers leaving the workforce.

43. The Scottish Government acknowledges that it needs to develop a more sophisticated approach to workforce modelling. It also recognises that more needs to be done to improve primary care data to inform workforce planning. In *NHS workforce planning: The clinical workforce in secondary care*, we recommended that the Scottish Government should:

- improve understanding of future demand
- demonstrate how training and recruitment numbers will meet estimated demand
- provide a clear breakdown of the costs of meeting projected demand through additional recruitment.

44. In April 2019, NHS Education for Scotland launched a data platform to bring together data on workforce supply. The platform includes data on different stages of the GP training pipeline and will give a better picture of how the numbers entering training will translate into the number entering employment in NHS Scotland, as well as the numbers of trainees leaving Scotland or going to work in other areas of the health service. The platform is available to both national and local workforce planners and should enable a more joined-up approach to workforce planning across the health service. The extent to which it can be used for primary care workforce planning will be limited until better data on the primary care workforce is available.

Workforce planning is fragmented

45. Nationally, responsibility for health and social care workforce planning sits in one division of the Scottish Government and responsibility for primary care sits in another (Exhibit 6, page 22). This creates a risk that workforce planning for different elements of the workforce is carried out separately, without a coordinated, strategic approach to planning the whole primary care workforce. The Scottish Government intends to create a revised structure to move towards a more strategic approach. This is due to be in place by November 2019.

46. Locally, NHS boards and integration authorities need to work together to plan the primary care workforce.

- NHS boards are responsible for contracting with GP practices to provide general medical services in their area. They are required to submit annual workforce plans and workforce projections, but most of their plans do not specifically mention primary care.
- IAs are responsible for planning, designing and commissioning primary care services. IAs are supposed to produce workforce plans, but not all have done so. They are also responsible for the development of primary care improvement plans, in collaboration with NHS boards and local GP subcommittees.

Exhibit 6

Workforce planning roles and responsibilities

Responsibility for planning the primary care workforce is fragmented.

National

Scottish Government

Health Workforce, Leadership and Service Reform Directorate – Health Workforce Division

Responsible for:

- National Health and Social Care Integrated Workforce Plan
- Workforce planning policy
- NHS pay and conditions

Directorate for Chief Nursing Officer

Responsible for:

- Nursing, midwifery and AHP workforce policy

Directorate for Mental Health

Responsible for:

- Mental Health Strategy 2017-2027
- Commitment to 800 additional mental health workers, including in GP practices

Directorate for Population Health – Primary Care Division

Responsible for:

- National Health and Social Care Workforce Plan Part 3
- Primary care workforce policy
- GMS contract

NHS Education for Scotland

NHS special board

Responsible for:

- Education and training of healthcare workforce
- NHS data platform

Strategic groups include:

- National Health and Social Care Workforce Plan Programme Board
- National Workforce Planning Group
- Workforce Planning Practice Subgroup

Strategic groups include:

- National GMS Oversight Group
- Remote and Rural Working Group
- Vaccinations Transformation Programme Board
- Primary Care IT Group

Regional

- Three planning groups for North Scotland, West of Scotland, and South-East and Tayside
- The regional groups have not produced workforce plans and are not required to do so
- Regional delivery plans were due to be published by autumn 2018. These were to include consideration of workforce but it is not clear when these will be published

Local

14 territorial NHS boards

- All NHS boards (except NHS Orkney) have workforce plans
- Contract for provision of primary medical services in their area
- As part of new GMS contract will be responsible for employing wider MDT members

31 integration authorities

- Responsible for planning and resourcing primary care services
- Development and implementation of PCIPs

Source: Audit Scotland

47. The National Health and Social Care Workforce Plan Programme Board was set up in November 2018. This is a group of representatives from the Scottish Government, COSLA and the Scottish Social Services Council. It was set up to oversee the development and delivery of the whole health and social care workforce planning programme and to provide clearer governance. Progress against the workforce commitments in the plans is the responsibility of the relevant policy teams in the Scottish Government.

48. The National GMS Oversight Group is responsible for overseeing implementation of the new GMS contract across Scotland. This group includes representatives from the Scottish Government, NHS boards, IAs and the Scottish General Practitioners Committee (SGPC). It does not include the professional organisations which represent the different healthcare staff groups which make up MDTs. In addition, there are several groups that provide advice and support on a range of issues such as remote and rural, IT and premises.

49. In *NHS workforce planning: The clinical workforce in secondary care*, we reported on the risk that the number of workforce plans and workforce groups could become a barrier to effective working. It is important that NHS boards and IAs work together with the Scottish Government to ensure their different plans align and that their respective roles are clear.

It is not clear how the Scottish Government's workforce commitments will contribute to the wider ambitions for primary care

50. The Scottish Government has made several commitments to train and recruit a range of primary care professionals (Exhibit 7, page 24). Planning the primary care workforce at a national level has been complex and challenging because most practices are run by self-employed GP partners who have been responsible for employing other practice staff. This has made it difficult to both understand the size and make-up of the existing workforce and also to plan for changes to the future workforce.

51. The commitments to train additional staff are either on track or have already been achieved. For the commitments relating to staff groups who work across the health service, such as nurses and paramedics, it is difficult to assess what the impact will be on the primary care workforce specifically, as those trained may go on to work outwith Scotland or in other parts of the health system. The Scottish Government's intention to increase the primary care workforce and expand the role of MDTs is clear, but it has not set out in detail how it anticipates that its workforce commitments will:

- reduce GP workload
- improve patient care and access
- meet future demand.

52. It is also unclear how these commitments link to workforce decisions being made at a local level. IAs are responsible for specifying the future primary care workforce they need to deliver services in their area. The Scottish Government did not use information from IAs about their requirements to inform its commitments and such information is not being used to monitor progress towards achieving them.

Exhibit 7

NHS workforce commitments

The Scottish Government has made a number of commitments to increase the NHS workforce.

Primary care commitments	Status	Progress
800 more GPs (headcount) over next 10 years	Not on track	Further information in paragraphs 53-54
100 more GP specialist training places from 300 to 400	Achieved	This was achieved in 2016 and 2017. There was a change in the way GP training was delivered in 2018, moving from a mixture of three- and four-year courses to only three-year courses. As a result, the number of new places advertised fell, but the overall number of training posts increased.
500 more health visitors by 2018	Achieved (late)	There was an increase of between 509.1 and 575.9 WTE, between March 2014 and March 2019. This is based on estimated 2014 data.
All GP practices to have access to pharmacist support by the end of 2021	Incomplete data	Funding for this has been provided by the Primary Care Transformation Fund. This had funded pharmacy support for about 68 per cent of GP practices as at December 2018. There is no information on how many of the remaining 32 per cent have pharmacy support funded through other means.
Up to 250 community link workers to work in GP surgeries by 2021 at least 40 being recruited in the coming year	Incomplete data	It is difficult to assess whether this commitment is on track because there is a lack of complete data on the current number of these workers, and on trends. Primary Care Improvement Plans report 120 community link workers in post in 2018/19.
Wider commitments with primary care impact		
2,600 more nursing and midwifery training places by 2021	On track	The Scottish Government sets the number of nursing university places for Scottish students. This increased to 4,006 for 2019/20. If current trends continue, it looks likely that an additional 2,600 places cumulatively will be achieved by 2021.
500 additional ANPs trained by 2021	On track	1,023 nurses received funding to undertake training, 425 from a primary or community care background, during 2017/18 and 2018/19. As at December 2018, 60 nurses had completed ANP education, with the Scottish Government expecting an additional 95 to have completed it by September 2019.
1,000 more paramedics training in the community over five years including 50 with enhanced skills to work in the community	On track	518 paramedics trained, and 57 more recruited between 2016/17 and 2018/19.
800 additional mental health workers over 5 years in A&Es, GP practices, police custody suites and prisons	On track	An additional 268 mental health workers were appointed as of 1 July 2019; 99 were in GP surgeries.

Incomplete data | Not on track | On track | Achieved

Source: Audit Scotland

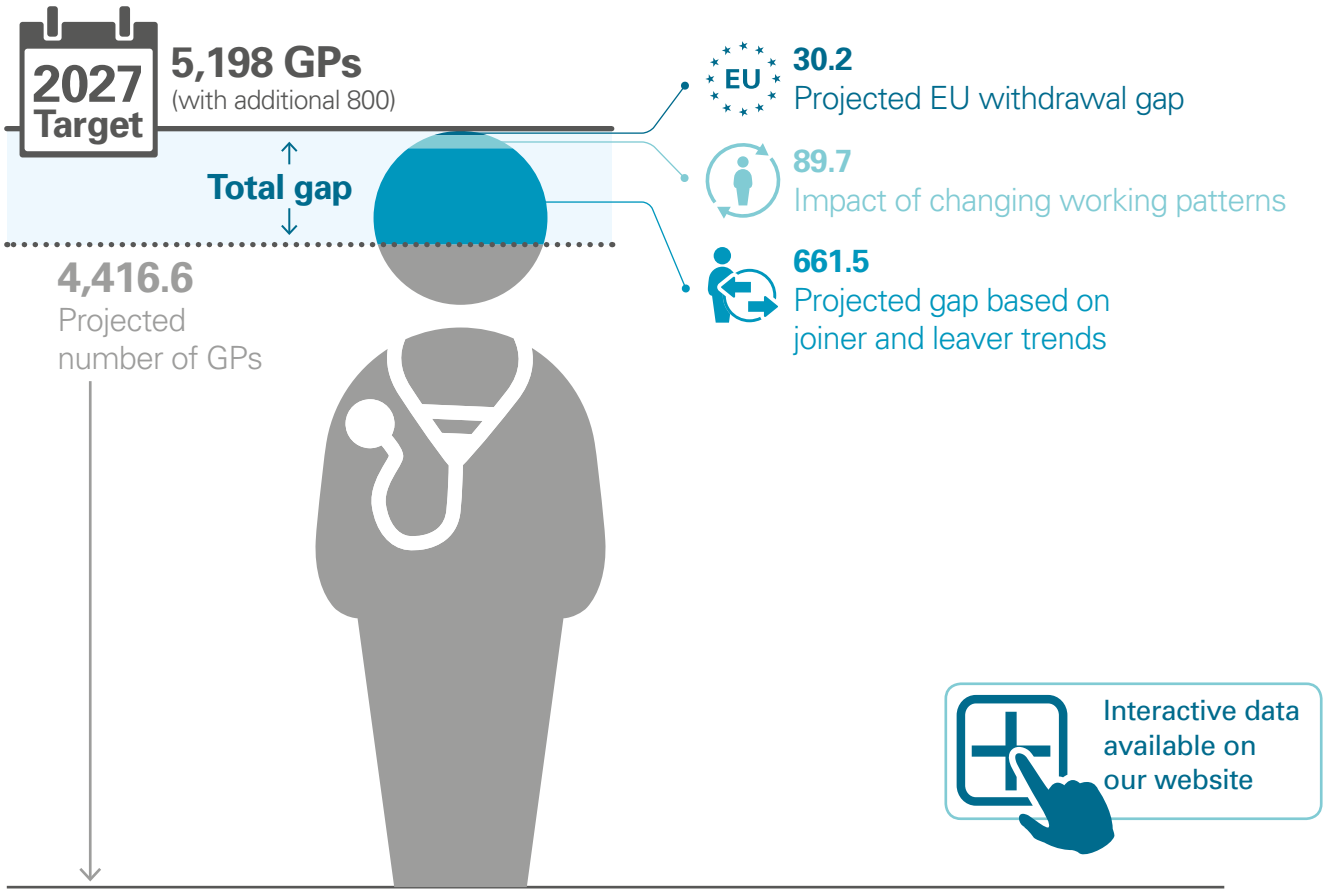
53. One of the most ambitious workforce commitments is the plan to have an additional 800 GPs over a ten-year period. Taking 2017 as the baseline, an additional 800 GPs would represent an 18 per cent increase, from 4,398 to 5,198. The Scottish Government has not set out what impact these additional GPs will have or how the target reflects retirement rates or changes in working patterns. It has not provided an assessment of how policy initiatives will contribute to reaching the target, or identified what the risks are if it is not achieved.

54. We have analysed the trend in GPs joining and leaving the NHS workforce in Scotland over the last ten years, the potential impact if ten per cent of GPs from the EU were to leave the workforce and the impact of changing working patterns. Our analysis indicates that GP numbers will remain broadly stable over the period 2017–27. Exhibit 8 shows the potential gap between the Scottish Government's commitment and the likely number of GPs, taking account of past trends and future pressures.

Exhibit 8

Potential shortfall in the number of GPs, 2027

Factors such as changing working patterns and past trends in GP joiners and leavers indicate that GP numbers are likely to remain fairly stable, which will make achieving the Scottish Government's commitment challenging.



Note: See Appendix 2 for methodology.

Source: Audit Scotland using ISD Scotland data

55. The target is based on a headcount of GPs, rather than WTE. With more GPs working part-time, this is likely to translate into considerably less than 800 additional WTE GPs (paragraph 21). This makes it difficult to assess:

- what impact achieving this commitment would have on the primary care workforce and pressures in primary care
- how it would contribute to the Scottish Government's aim to change the way primary care is delivered through the use of MDTs.

56. Some individual boards have considered these issues as part of local workforce planning. For example, in 2017, before the new GMS contract came into effect, the IAs in Ayrshire and Arran looked at the age profile of their GP population and at trends in recruitment and working patterns. On this basis, they calculated that for every GP leaving the workforce they would need to recruit an additional 1.6 GPs to maintain workforce capacity. Based on trends in retirement, they projected that they were likely to need an additional 80 GPs by 2022, without factoring in any additional recruitment needed to increase the workforce. This level of GP recruitment was assessed as being difficult to achieve. To address this the IAs developed a primary care programme to focus on implementing multidisciplinary working in practices and to divert activity away from GP practices where appropriate.

A lack of data on the primary care workforce will make it difficult to assess whether the GMS contract is achieving its aims

57. In 2008, in our report on the previous GMS contract, we highlighted that there was a lack of basic data on general practice, making it difficult to plan the workforce effectively. We recommended that:

- the Scottish Government collect robust data before implementing major schemes so that it could base decisions on accurate information
- the Scottish Government and NHS boards collect comprehensive data on GP numbers and GP practice staff numbers to support workforce planning at national and local levels.[26]

58. Between 2004 and 2018, GP practices were not obliged to provide data on staff employed by the practice. Lack of data on practice-employed staff means that there are no accurate figures on the size and make-up of the primary care workforce.

59. In 2018/19, £870.5 million was spent on GMS funding, making up 6.4 per cent of the total health budget. This is a real terms increase of 13 per cent since 2013/14, when GMS funding made up six per cent of the health budget.[27] The latest published data on GP practice funding is for 2017/18. About £794 million was paid to GP practices. This covers the cost of delivering core primary care services, including payments to GP partners and staff salaries for those employed directly by the practice. It also includes additional payments for premises, seniority payments for staff and payments for some additional services commissioned by NHS boards. There is no data available on how much of this is spent on staff, so primary care workforce costs cannot be separately identified.

60. Accurate workforce data is essential for effective workforce planning both nationally and locally. Without a clear picture of the size and make-up of the primary care workforce, WTE as well as headcount, it is difficult to plan the workforce to meet future need and to assess progress against plans to increase the workforce. Similarly, without accurate information on the costs of the primary care workforce, it is difficult to project what the cost of expanding the workforce will be. Some work has been done to assess the pharmacy workforce needed to meet future demand (Case study 2).

Case study 2

Pharmacy modelling

The Scottish Government commissioned the University of Strathclyde and Robert Gordon University to carry out some work on the involvement of pharmacists in GP practices. The results were published in November 2018. The universities looked at the pharmacy workforce across Scotland to get an understanding of the workforce and to model future demand.

They wanted to calculate the potential workforce needed to take on two areas of work: polypharmacy clinics, for patients receiving prescriptions for four or more medications, and requests for non-repeat medication. To do this, they carried out case studies in NHS Greater Glasgow and Clyde and NHS Lothian. As both NHS boards already collect data on pharmacy activity and demand, it was possible to project the number of WTE pharmacists required to meet demand in these areas and model this nationally.

For example, for acute medication requests they calculated the time taken and corresponding WTE figure using both the NHS Greater Glasgow and Clyde model, and the NHS Lothian model.

	Process two acute prescriptions for all patients	
	Estimated hours	Estimated WTE staff
Scotland (NHS GGC 3 mins per acute prescription)	**196,702 hrs**	**114.0 WTE**
Scotland (NHS Lothian 8.6 mins per acute prescription)	**563,880 hrs**	**326.9 WTE**

As part of this work, they recommended that NHS boards follow a consistent approach to collecting and reporting data on pharmacy activity.

Source: Audit Scotland using *Evaluation of pharmacy teams in GP practice report*, Robert Gordon University and the University of Strathclyde

61. As part of the new GMS contract, GP practices will be required to provide data on income and expenses and on practice-employed staff. Arrangements for the collection of this data were not in place when the contract came into effect in April 2018. The contract document states that data collection to inform phase 2 would start in 2018/19. This data collection was piloted in April 2019 and is due to be rolled out to all GP practices over the summer of 2019. This data will be used to inform the development of Phase 2 of the contract. It is expected to include the data previously collected through the primary care workforce survey.

62. As part of Phase 2, the Scottish Government plans to introduce a guaranteed income range for GPs, similar to that currently in place for consultants, and to directly reimburse practice expenses. This is due to come into effect from 2020/21, but there is a risk that Phase 2 will be delayed or based on limited data.

National data on activity and demand has not been available since 2012

63. Since 2012, the Scottish Government has been working with NHS National Services Scotland to improve the extraction of data from GP practice records by developing the Scottish Primary Care Information Resource (SPIRE). In December 2018, SPIRE had been deployed in 93 per cent of Scottish GP practices.

64. Until 2013, data on consultations with GPs and other members of practice teams was collected from a sample of six per cent of practices. This was used as the basis for estimates for Scotland. SPIRE is intended to provide an improved source of activity data and was originally due to be operational in 2016. As implementation has taken longer than planned, estimates of practice workload are considerably out of date, including those used as the basis for the funding allocation formula for the new GMS contract.

65. As part of the GMS contract, the Scottish Government intends to collect information on hours worked by GPs, but there is no clear timetable in place for when this data collection will begin. To fully understand primary care activity and demand, data is needed on the number of consultations with all staff groups. The Scottish Government is in the early stages of modelling work intended to give it a better understanding of demand and to assess the potential impact of the range of commitments included in its Health and Social Care Delivery Plan. This work is currently limited in its ability to model the impact of primary care commitments by the lack of robust data. However, the Scottish Government hopes that in the longer term it will have an analytical model in place that can be used to model workforce capacity across health and social care.

66. As SPIRE is not yet fully deployed, there is no up-to-date information at a national level on what activity is being moved to other MDT members and the impact that this is having on GP workload. Without this data, the Scottish Government will not be able to assess whether the new contract is achieving the aim to change the role of the GP and reduce GP workload.

67. The development of MDTs depends on having the digital and physical infrastructure in place to enable joint working. Different professional groups currently use different records management systems. This makes it difficult for MDT members to share information. MDTs will operate differently in different local contexts, but for those based in GP practices there can be challenges in accommodating an expanded MDT on the existing premises. The Scottish Government has asked IAs to clearly set out in the second iteration of the PCIPs how they are identifying the digital and physical infrastructure needed locally to

deliver the priorities set out in the MOU accompanying the GMS contract. The costs of digital infrastructure to support additional staff are to be included in the PCIPs as core workforce costs.

Putting the workforce in place to deliver the planned primary care changes will be challenging

68. The Scottish Government has implemented a range of initiatives to increase recruitment and retention of GPs. Between 2015/16 and 2016/17, it invested £2.5 million on recruitment and retention. In 2017/18, it increased this funding to £5 million and provided a further £7.5 million in 2018/19, bringing the total investment to £15 million. Initiatives include:

- ScotGEM: a four-year graduate entry medical course, open to students who have graduated with a degree other than medicine. The course has a focus on general practice and rural working. Students can also apply for a bursary of £4,000 per year if they agree to work in Scotland's NHS for at least one year for every year they received the bursary, after graduating. There are currently 55 students enrolled on the course.

- Pre-medical entry courses at Glasgow and Edinburgh universities: these courses are designed to widen access to medical training by providing 40 places for students from disadvantaged backgrounds to prepare for undergraduate medical training.

- The Scottish Rural Medicine Collaborative: this is a programme to develop ways to improve recruitment and retention in rural areas.

- A relocation package and 'golden hello' scheme: these measures are intended to encourage GPs to work in 160 eligible rural practices.

- A marketing and recruitment campaign: the campaign aims to attract GPs from the rest of the UK and overseas to work in Scotland.

- Mentoring and coaching programmes: the objective is to help retain the existing workforce.

- The Scotland GP returners programme: designed to make it easier for GPs who have taken a break to return to general practice.

69. The Scottish Government has reported that, between 2015/16 and 2017/18, an additional 39 GPs were recruited as a result of this recruitment and retention funding. Despite the additional funding, based on the number of additional GPs recruited to date, and the scale of pressures on the workforce, it will be challenging for the Scottish Government to recruit an additional 800 GPs by 2027.

70. Some areas have implemented local initiatives to improve recruitment and retention of GPs. NHS Ayrshire and Arran runs a 'GPs with enhanced role' programme, which enables GPs to work part time in a practice and part time in an acute specialty.

71. The expansion of the MDT workforce depends on the availability of staff across the various professional groups with the necessary skills and experience. Although the Scottish Government has made commitments to train additional

GPs, nurses, ANPs and paramedics, this increase in supply will take time to result in an increase in the available workforce. The Scottish Government does not currently control the number of training places for AHPs, making it harder to plan for numbers entering the workforce. The National Health and Social Care Workforce Plan Part 3 notes that NHS boards have indicated that there are challenges with recruitment across the AHP workforce and states that the Scottish Government is considering options for taking a more managed approach to training AHPs. There is no published timescale for this work.

More needs to be done locally to plan the future workforce

72. In support of the 2018 GMS contract, all 31 integration authorities were asked to develop the first versions of their primary care improvement plans by 1 July 2018. There was considerable variation in the detail provided in the initial plans, particularly in relation to projected workforce numbers and costs. The Scottish Government provided additional guidance on what the second iteration of PCIPs should cover. These were due as soon as possible after 1 April 2019. IAs are now also required to submit a tracker every six months to report on progress against the PCIPs.

73. PCIPs also provide an opportunity for the Scottish Government to collect local-level information on demand. Some plans use local monitoring data to assess trends in demand. For example:

- The three IAs in Ayrshire and Arran worked together to collect data on the recent increase it has seen in demand on primary care services, including a seven per cent increase in the rate of consultations per 1,000 patients since 2015.

- East Dunbartonshire IA has projected demand in 2025 based on a model using data from practices across Scotland and population estimates for NHS Greater Glasgow and Clyde. It estimates that face-to-face GP consultations across Greater Glasgow and Clyde will increase from 3.77 million to 4.26 million per year. It also projects a rise in district nursing contacts of 25.7 per cent by 2025.

74. Based on an analysis of national trend data, for some staff groups the PCIP projections would require the workforce to grow at a much faster rate than it has in previous years (Exhibit 9, page 31). This indicates that local projections will be difficult to achieve, regardless of available funding, without a substantial increase in workforce supply across the country over the next three years.

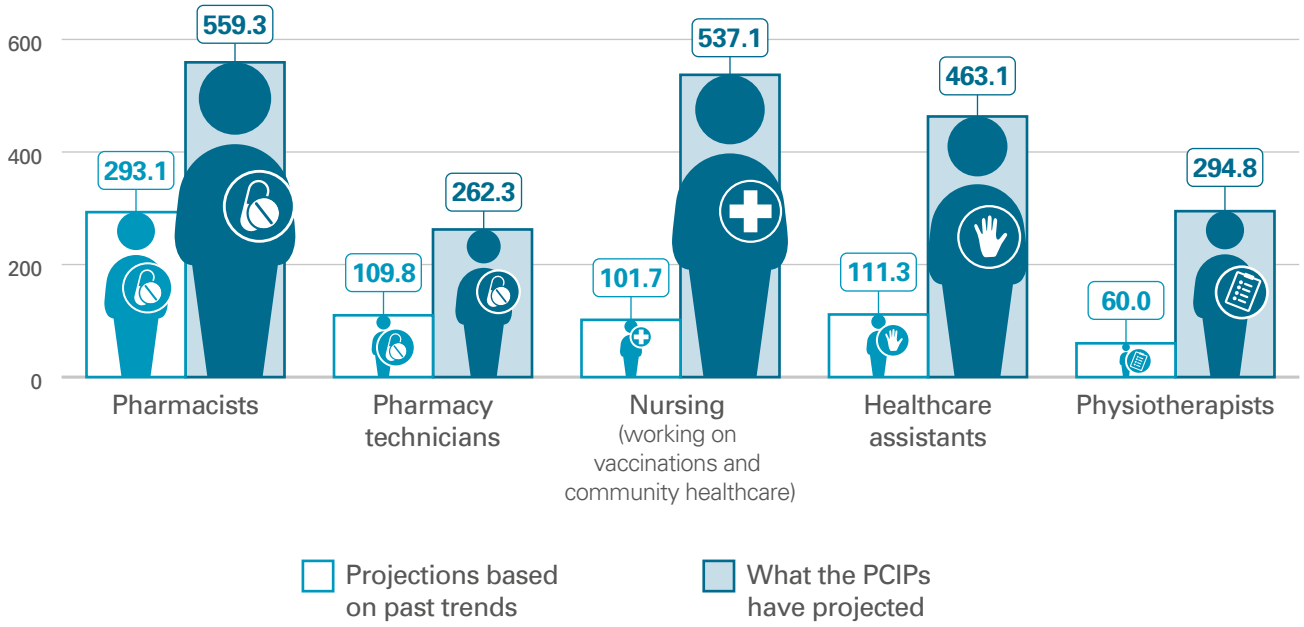
75. Integration authorities have identified issues with the availability of staff as one of the main barriers to implementing their PCIPs. As all IAs are working to expand their primary care workforce during Phase 1 of the GMS contract, there is a significant risk that they will be in competition for the same limited workforce. This may cause additional recruitment challenges in rural areas, where recruitment is already difficult.

76. Locally, some NHS boards and IAs are taking steps to support the expansion of the workforce and development of new roles. For example, to help support the recruitment and training of ANPs, NHS boards in the west of Scotland have come together to establish the West of Scotland Advanced Practice Academy. The academy has developed a coordinated training and development programme for ANPs, working in collaboration with general practice.

Exhibit 9

Workforce projections

The numbers of staff that IAs are projecting that they will need over the next three years represent much larger increases in staff than have been seen in recent years.



Source: Audit Scotland using PCIPs and ISD Scotland workforce data

77. It is likely that the expansion of the primary care practice-based workforce will have unintended consequences for workforce numbers in other parts of the NHS. In some areas, NHS boards are struggling to find staff to work in out-of-hours services. There is a risk that this situation will worsen if staff find working in a practice more attractive. For example, over the period 2017/18 to 2018/19, 12 nurses left the out-of-hours service in NHS Lothian to work in GP practices. Similarly, pharmacists have raised concerns that the increase in pharmacists working in GP practices is leading to staff shortages in community and hospital pharmacies.

78. Part 3 of the national workforce plan does not assess the potential impact of primary care workforce expansion on other parts of the healthcare system. In *Changing models of health and social care*, we reported on the benefits of taking a whole-system approach to planning health and social care services, which would assess the impact of changes to the primary care workforce on the NHS more widely.

Endnotes

1 *Health and social care: medium term financial framework*, the Scottish Government, October 2018.

2 *The future of primary care in Scotland: A view from the professions*, Primary Care Clinical Professions Group, September 2016 (updated May 2017).

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

4 *General Medical Services contract in Scotland: a short guide*, Audit Scotland, May 2019.

5 *NHS workforce planning: The clinical workforce in secondary care*, Audit Scotland, July 2017.

6 *General practice – GP workforce and practice list sizes 2008–2018,* ISD Scotland, December 2018.

7 *NHS in Scotland 2018*, Audit Scotland, October 2018.

8 *Healthy life expectancy for Scottish areas, 2015-2017,* National Records of Scotland, 2019.

9 *General practice – GP workforce and practice list sizes 2008–2018,* ISD Scotland, December 2018.

10 *From the frontline – the changing landscape of Scottish general practice*, Royal College of General Practitioners Scotland, June 2019.

11 *Primary care workforce survey Scotland 2017,* ISD Scotland, March 2018.

12 *Health select committee inquiry: Impact of a no-deal Brexit on health and social care*, General Medical Council, 2018.

13 *The relationship between the primary medical qualification region and nationality at the time of registration, 2017 and 2018*, General Medical Council, November 2018.

14 *The NMC register*, Nursing and Midwifery Council, March 2018.

15 2018 National training survey, General Medical Council.

16 *From the frontline – The changing landscape of Scottish general practice,* Royal College of General Practitioners Scotland, June 2019.

17 *NHS in Scotland 2018*, Audit Scotland, October 2018.

18 Our Voice Citizens' Panel is a large, demographically representative group of citizens selected at random. The panel is used to gather information on the views of the public on health and social care policy and services.

19 *Survey on the use of digital technologies for healthcare improvement, using and sharing personal health and social care information and access to healthcare professionals other than doctors,* Our Voice Citizens' Panel, January 2018.

20 *Evaluation of pharmacy teams in GP practice,* Robert Gordon University and University of Strathclyde, November 2018.

21 *NHS Scotland payments to general practice 2017-18*, ISD Scotland, November 2018, *Practice populations by urban/rural classification,* ISD Scotland, December 2018. Urban/rural classifications are based on the location of the practice, patients may not necessarily live in areas with the same urban/rural classification as the practice itself.

22 *Rural GP Association of Scotland submission of 14 October 2018*, The Scottish Parliament, October 2018.

23 *Equality impact assessment on the new GMS contract*, Scottish Government, 2018.

24 *Primary care: National monitoring and evaluation strategy*, Scottish Government, March 2019.

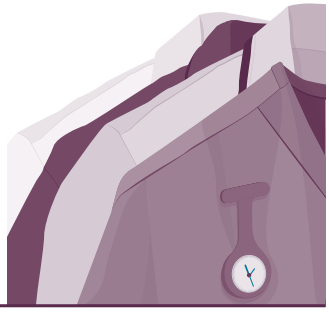
25 *National Health and Social Care Workforce Plan Part 3 – Improving workforce planning for primary care in Scotland*, Scottish Government, April 2018.

26 *Review of the new General Medical Services contract*, Audit Scotland, July 2008.

27 *Scottish Budget: draft budget 2018-19*, Scottish Government, December 2018.

Appendix 1

Progress on implementing the recommendations made in *NHS workforce planning: The clinical workforce in secondary care*



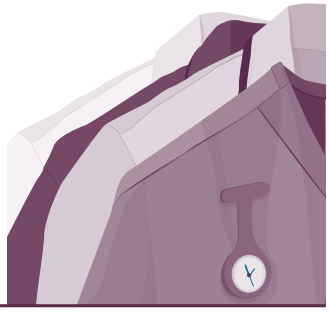
Recommendation	Progress
The Scottish Government should:	
Improve understanding of future demand to inform workforce decisions, including: • collating, comparing and monitoring NHS boards' assessments of demand and supply to help form a national picture and manage risks • carrying out scenario planning on the future population health demand and workforce supply changes (such as staff retiring), including how this will affect the types of treatments provided • considering and clarifying potential future skills mix with NHS boards and stakeholders to determine how a future team can work to meet this demand.	The medium-term financial framework was published in 2018, and includes estimates of increases in demand, as a percentage per year. NHS NES launched a data platform in April 2019, bringing together a wide variety of NHS and social care workforce data. It includes both training and employment data. The platform is being tested and developed in collaboration with stakeholders. Once further developed, this will give workforce planners a better picture of supply and allow scenario planning on future workforce numbers. Still in development: • the publication of the integrated health and social care workforce plan, originally expected in 2018. This may address some of these issues, including scenario planning for future demand • updated workforce planning guidance for boards, originally due in 2018 • further development and implementation of the modelling tool that could be used to look at demand, workforce and cost.
Demonstrate how training and recruitment numbers will meet estimated demand for healthcare – if it does not, document and cost how the gap between demand and supply in the future will be covered.	The NHS NES data platform will give a better picture of numbers coming through training and into employment from the supply side. We would hope to see more on this in the upcoming workforce plan.
Provide a clear breakdown of the costs of meeting projected demand through additional recruitment across all healthcare staff groups.	We would hope to see this in the upcoming workforce plan.

Cont.

Recommendation	Progress
Demonstrate how policy initiatives, such as safe staffing levels and elective centres, are expected to affect staffing requirements in NHS boards.	We would hope to see this in the upcoming workforce plan.
Set out the expected transitional workforce costs and expected savings associated with implementing NHS reform. This includes collating transitional costs in relation to moving staff into elective centres and into the community, and savings through increased efficiencies.	We would hope to see this in the upcoming workforce plan.
Determine the data required for decisions on the workforce. This will include data on the training pipeline for medical and AHP staff, data on EU citizens working in the NHS in Scotland, and agency spending by professional group.	NHS Education for Scotland work on the data platform will bring together the workforce data sources available, to be used for workforce planning. This went live in April 2019.
Progress arrangements to create national and regional staff banks.	A national service model for radiology is due to be launched in summer 2019. For most other specialties, the Scottish Government has decided against the creation of a national staff bank because evidence suggests staff are only likely to accept shifts within a 15-mile radius of their home.
NHS boards should:	
Produce future plans as well as supply criteria. This would include: • projecting their future workforce against estimated changes in population demography and health factors • producing plans which detail the expected workforce required, supported by analysis of workforce supply and demand trends.	Not in the scope of this audit.
Fully cost the workforce changes needed to meet policy directives, such as the shift to community-based care, proposed elective centres, safe staffing levels and more regional working.	Not in the scope of this audit.
Improve the accuracy of budgeting for agency spending.	An analysis of financial performance report data for the NHS in Scotland in 2018 found that 12 of 14 boards overspent against their pay budget.

Appendix 2

Methodology



Methodology for GP projections (Exhibit 8, page 25)

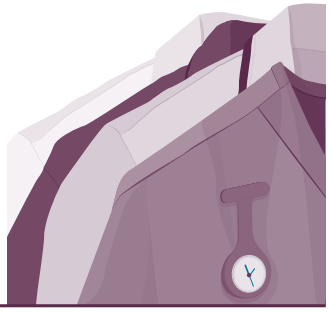
- Total number of current and historic GPs is based on the GP headcount, excluding trainees, published by ISD Scotland. The number of GPs needed in the future has been calculated by taking the headcount in 2017 and adding 800.
- Leaver and joiner projections are calculated by forecasting forward based on trends over the previous ten years, using data on GPs starting or leaving the NHS in Scotland provided by ISD Scotland. Alternative scenarios used factored in the number of ScotGEM graduate training places and the impact of increasing numbers of retirements.
- Potential gap due to EU withdrawal has been calculated by assuming 3.7 per cent of GPs are from the EU (based on GMC data for all doctors). Surveys have shown as many as 40 per cent of doctors from the EU are intending to leave, so we have assumed ten per cent may genuinely leave. These potential leavers due to EU withdrawal have been removed from the overall GP number, as well as future GP new starts.
- Given that the GP workforce demographics show a decreasing number of GP partners, an increasing number of women and that about one in three are over 50, it is likely that an increasing number of new GPs will be needed to replace those who leave, due to changing working patterns. To demonstrate the impact that this could have we have assumed that the current ratio of about 1.2 GPs for every 1 WTE will increase to about 1.4.
- For each of these factors a range of scenarios was produced, and those that may be most likely, based on the available evidence, were selected. Further data on the alternative scenarios is presented in the linked background data.

Methodology for cost per patient (paragraph 36, page 19)

- The cost per patient for the most rural and most urban practices uses data from the ISD Scotland GP payments publication and published data on the urban/rural categorisation of GP practices.
- Cost per patient for each practice was calculated by dividing the global sum plus correction factor by the number of people on the practice list. Then the average was calculated for the most and least rural practices, for comparison.

Appendix 3

Advisory group members



Audit Scotland would like to thank members of the advisory group for their input and advice throughout the audit. Members sat in an advisory capacity only. The content and conclusions of this report are the sole responsibility of Audit Scotland.

Member	Organisation
Richard Foggo	Scottish Government
Miles Mack	Rural GP
Moya Kelly	NHS Education for Scotland
Lorna Greene	Royal College of Nursing Scotland
Robert Peat	Allied Health Professions Federation for Scotland
Carey Lunan	Royal College of General Practitioners
David Prince	British Medical Association
Aileen Bryson	Royal Pharmaceutical Society Scotland
David Leese	Renfrewshire Health and Social Care Partnership

NHS workforce planning – part 2

The clinical workforce in general practice

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ITEM No …5……..

REPORT TO: **PERFORMANCE AND AUDIT COMMITTEE – 26 NOVEMBER 2019**

REPORT ON: **CLINICAL, CARE AND PROFESSIONAL GOVERNANCE GROUP - CHAIRS ASSURANCE REPORT**

REPORT BY: **CLINICAL DIRECTOR**

REPORT NO: **PAC39-2019**

1 PURPOSE OF THE REPORT

To provide an update to the Performance and Audit Committee on the business of the Dundee Health and Social Care Clinical, Care and Professional Governance Group (CCPGG). An exception report will be submitted by Clinical Director, in his role of the Chair of the Clinical, Care and Professional Governance Meeting to each Performance and Audit Committee to provide assurance of the governance systems and processes within the Dundee Health and Social Care Partnership.

2 RECOMMENDATIONS

It is recommended that the Performance and Audit Committee:

2.1 Notes the contents of this report and the exception report attached at Appendix 1.

2.2 Notes the assurance provided by the Clinical Director that the governance systems and processes operating within the Health and Social Care Partnership are identifying, monitoring and striving to address the clinical, care and professional governance issues raised within the partnership.

3.0 FINANCIAL IMPLICATIONS

Improvement actions described within this report are funded within current resource allocated to the Health and Social Care Partnership.

4.0 MAIN TEXT

4.1 Current Clinical, Care and Professional Governance Arrangements in Dundee Health and Social Care Partnership

4.1.1 Clinical, Care and Professional Governance (CCPG) is the process by which accountability for the quality of health and social care is monitored and assured. It should create a culture where delivery of the highest quality of care and support is understood to be the responsibility of everyone working in the organisation, built upon partnership and collaboration within teams and between health and social care professionals and managers.

4.1.2 The approach for CCPG within integrated services in Tayside is set out in the agreed framework – Getting It Right for Everyone: Clinical, Care and Professional Governance Framework. CCPG relies on all of these elements being brought together through robust reporting and escalation processes using a risk management approach to ensure person-centred, safe and effective patient care.

4.1.3 In Dundee HSCP key elements of CCPG are monitored through the following forums:

- CCPG Leadership Huddle ('the Huddle') which meets on a weekly basis
- CCPG Forum (CCPGF) which meets on a 2 monthly basis
- CCPG Group (CCPGG) which meets on a 2 monthly basis
- Primary CCPG Groups sit at a service level and meet regularly in accordance with service need

These groups provide the forums to monitor, review, discuss and disseminate CCPG issues, identify any risks and mitigate/escalate these as required.

4.1.4 The CCPGF and CCPGG review all action plans in relation to the implementation of the CCPG framework, and implement the subsequent dissemination of learning that arises from all Local Adverse Event Reports (LAERs); Organisational Adverse Events Reports (OAERs); Significant Case Reviews (SCRs); Case Reviews; Scottish Public Sector Ombudsman (SPSO) reports and review all risks recorded on the DHSCP Datix risk register on a 2 monthly basis. In addition, the CCPGF and the CCPGG review all action plans and implement the dissemination of learning that arises from all inspection reports and standards, guidelines and relevant legislation.

4.1.5 The Huddle reviews all adverse events reported on Datix and ensures that themes and learning are identified and discussed at the CCPGF and CCPGG.

4.1.6 The following table sets out the reporting arrangements for the Dundee Health and Social Care Partnership (DHSCP).

	CCPGF	**CCPGG**	**CQF**
Scorecard	Full	Exceptions (from scorecard)	Persistent Exception (Three Reports) Exceptions Affecting Multiple Teams Level of Risk (High)
Datix Themes/ Action Taken	Full All Reported and Themed	Exceptions (Individual/Themes)	Persistent Exception (Three Reports) Exceptions Affecting Multiple Teams Level of Risk (High)
Red Events	All	All	Overview – Themes/Numbers
LAER/OAER/SCR	All Reported and Learning Shared	High Level Summary	Exceptions Organisational Learning Organisational Risk
Complaints (and SPSO)	All – Learning shared	Quality Report (Sample) Upheld Status Report SPSO + Exception	SPSO Numbers Organisational Learning
Risks	All (Detailed in scorecard)	High Level Report with Assurance Statement Persistent Long Term Risks Transient Risks	Overview Report Persistent Exception (Three Reports) Exceptions Affecting Multiple Teams Level of Risk (High)
Inspection Reports	Action Plan Produced Per Team (where applicable)	Action Plan Produced Per Team (where applicable)	Overview Statement
Standards/Legislation/ Guidelines	New Standards Reported	Agenda items ad hoc	Organisational Impact

4.2. **ASSESSMENT**

4.2.1 The DHSCP Clinical Director is required to provide information to both DHSCP and the CQF in order that both organisations can achieve assurance as to the matters of CCPG within the partnership. Agreement was reached that exception reports would be provided to the PAC and that regular reports would be provided to the CQF. The exception report covering the period up to 30th September 2019 is attached at Appendix 1.

4.2.2 The exception report sets out the issues considered by the CCPFG and highlights the following:

- Three new risks agreed and recorded – these relate to psychiatry of older people services and substance misuse services. These risks were previously reported to the PAC and are currently being addressed.
- Difficulties in recruiting to vacant post was noted as an ongoing issue across all services.
- Kingsway Care Centre received a positive report from the Mental Welfare Commission which identified good practice across the service. It was noted that the service had not yet installed the recommended observation windows in bedrooms. This work is currently underway.

4.2.3 The Clinical Director, in his role as Chair of the CCPGG is satisfied that the current arrangements provide opportunity to identify, monitor and strive to address the CCPG issues raised within the partnership.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment and Risk Management. There are no major issues.

6.0 RISK ASSESSMENT

Risk 1 Description	There is a risk that Clinical Care and Professional Governance arrangements are not implemented affectively leading to poor practice and service delivery
Risk Category	Quality of Service
Inherent Risk Level	Likelihood 2 x Impact 4 = Risk Scoring 8 (Moderate)
Mitigating Actions (including timescales and resources)	Governance arrangements are reviewed through the structures described in the report.
Residual Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6 (Moderate)
Planned Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6 (Moderate)
Approval recommendation	Given the mitigating actions in place, the risk is deemed to be manageable.

7.0 CONSULTATIONS

The Chief Officer and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPER

None.

David Shaw
Clinical Director

Date : 15 November 2019

Diane McCulloch
Head of Health and Community Care

Matthew Kendal
Lead AHP

APPENDIX 1

DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP CLINICAL, CARE AND PROFESSIONAL GOVERNANCE EXCEPTION REPORT

PERIOD COVERING JUNE –SEPTEMBER 2019

1. Clinical, Care and Professional Governance Assurance Processes

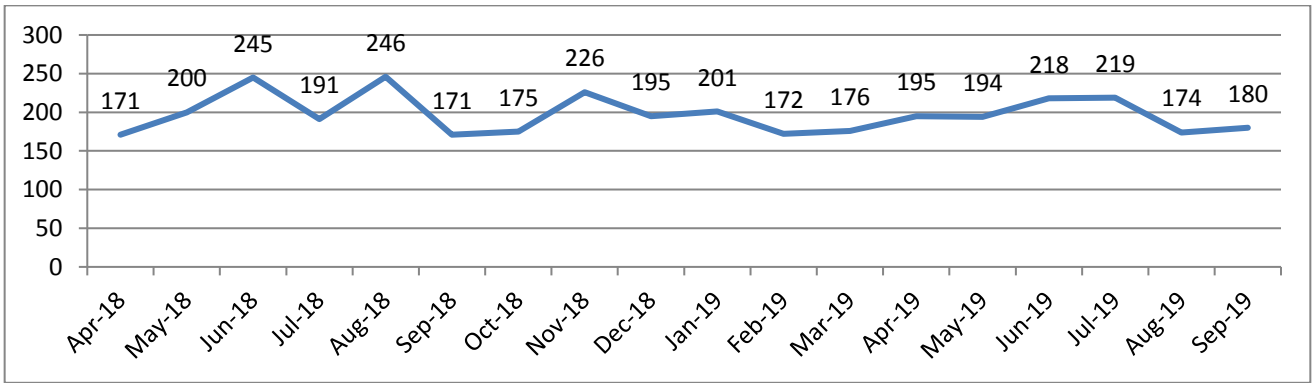
Dundee Health and Social Care Partnership (DHSCP) continues to review the processes for Clinical, Care and Professional Governance (CCPG) in order to ensure processes and scrutiny is of a level which can provide the required assurance. A "Taking Stock" event took place in December 2018 to reflect on the current CCPG arrangements across DHSCP. It was identified that while some elements of governance were working well there remained gaps. The following actions were implemented within this reporting period:

- The Clinical, Care and Professional Governance Group (CCPGG) agreed that future meetings would include an exception report from each Primary Governance Group. The HSCP will agree a core set of measures to be reported at every meeting by every service. In addition, it is expected that services will also develop a set of service specific measures.
- Operational services that do not sit within the locality model and therefore do not currently have a Primary Governance Group were identified, and the reporting requirements of these services will be scoped.
- A series of workshops will run from October to December 2019 to review and finalise the core and specific datasets and the reporting timescales from the Primary Governance Groups to the Clinical, Care and Professional Governance Group. A Draft Terms of Reference has been developed for the Primary Governance Groups.
- The group received a presentation from the Neighbourhood Services Team entitled 'Tackling Health Inequalities in Dundee': An Integrated Approach' which was well received and detailed the good work being undertaken in this team. It also highlighted some gaps in governance reporting which will be addressed via the workshops mentioned above.

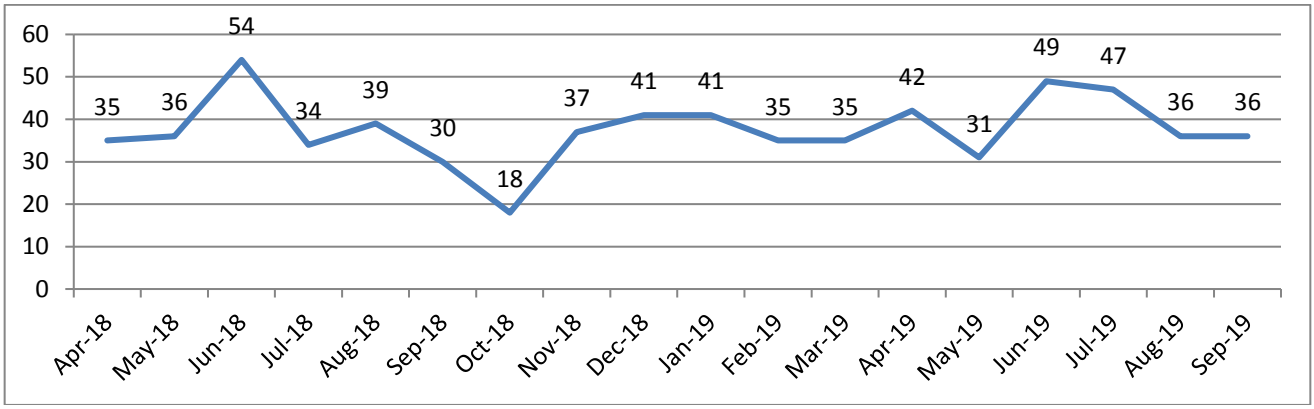
2. Adverse Events Report

The following four tables present adverse event data for DHSCP from the Datix system. It is recognised that Datix is predominately used by Health staff within the DHSCP and therefore the numbers may not reflect all the adverse events that have occurred.

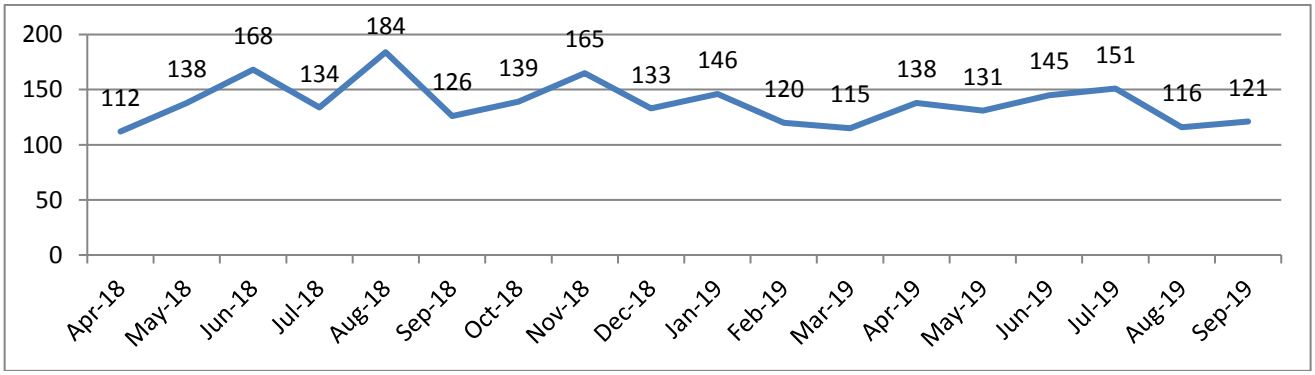
Graph 1. Total Number of Adverse Events and Near Misses Reported within Datix



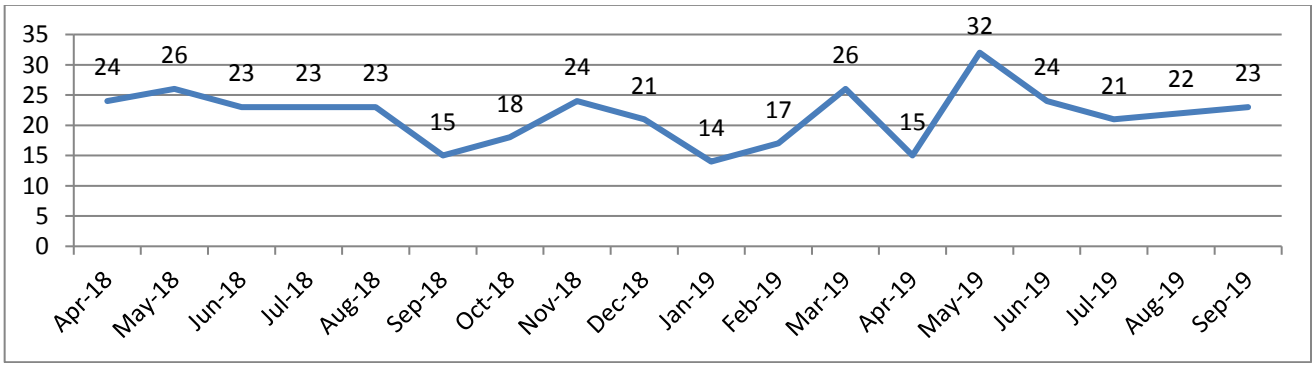
Graph 2. Number of Adverse Events with Harm Reported within Datix



Graph 3. Number of Adverse Events without Harm Reported within Datix



Graph 4. Number of Near Misses Reported within Datix



The number of overdue adverse events within Datix continues to increase. There are currently 204 green, yellow and amber adverse events overdue for completion within Dundee HSCP. Of those currently outstanding, 189 have been verified and 15 are unverified. In addition, there are 60 overdue red adverse events. Whilst this is the same number as reported in June 2019, it should be noted that the number of overdue red events from 2017 has reduced 14 to 8. One of these overdue adverse events dates back to 2016. This was awaiting review from oncology. There are 30 outstanding from 2018, with the remaining 21 from this year. Support has been offered to services from the Clinical Governance & Risk Management Team to address this. Monthly reports on overdue adverse events are circulated within DHSCP.

3. DHSCP Risks

A report summarising the DHSCP Risk Register within Datix was presented to the CCPGG and the Forum. The following amendments to the register were highlighted:

- Three previously pending risks have now been agreed as current risks on the register. These relate to workforce issues and environmental issues
- Two new risks are under development and therefore added to the register as pending risks. These are both in relation to the service redesigns within Integrated Substance Misuse Services.

It was recognised that several risk review dates were overdue, and that a number of risks did not appear to be moving towards the planned risk exposure rating. Challenges with managing risks are expected to be highlighted through exception reports to the CCPGG. Support and training has also been offered by the Clinical Governance and Risk Management Team and this will continued to be monitored.

Risk Maturity Assessment

In September 2018, the Performance & Audit Committee received a risk maturity assessment from Internal Audit. Although the partnership was praised for progress, there were a number of issues identified to take forward. There is a Risk Management Action Plan in place which is Tayside-wide. One of the key areas noted was while there is a high level risk register there is no evidence of operational risks going to the high level register. It is necessary to identify and formalise the links between the strategic operational risk registers recognising the key roles of this group and the Performance and Audit Committee. There are different systems used for recording risks and not all are formally reported to the CCPGG. The CCPGG have requested a further report setting out the actions to be taken to align and ensure that all relevant risks are recorded consistently and monitored effectively.

Recruitment/Vacancies

There continue to be issues in relation to the process of recruitment, both within NHS Tayside and DCC. The situation continues to be monitored and areas of significant risk continue to be escalated. Particular risks have been noted within the district nursing service and a range of roles supporting the Primary Care Improvement Initiative (which delivers the new GP contract). It was further noted that there remain difficulties in recruiting to direct service delivery posts within nursing and social care.

Integrated Substance Misuse Service

The Drug Commission report has been published and recommendations are being discussed at both a strategic and operational level. It was noted that specific recommendations regarding the clinical model of care were made. Proposals for change are being developed and will be presented to the CCPGG in due course.

The commission report highlighted issues that had been previously brought to the Clinical, Care and Professional Governance Group for noting. These include capacity issues, ability to deliver clinical services against increasing demand, levels of caseloads and the ability to respond to statutory duties. The report recognised that the pressures within the service will impact on staff and steps are being taken to support staff, at this challenging time. Workforce plans are being developed. The previously identified risks remain a high priority.

Mental Health Services

There have been a number of positive developments since the previous meeting. There are now two full time locum psychiatrists working at Wedderburn. This has helped change significantly the way referrals are managed, and the caseloads in terms of reducing waiting times. Saturday clinics were in place during September. These were run by psychiatrists and nursing staff. A communication was sent to GPs recently and this will be appended to an exception report. The Alloway Team now have an additional psychiatrist working with them. This will undoubtedly relieve some pressure and this will continue to be closely monitored.

A new Clinical Lead for all Community Mental Health and Learning Disability Services in Dundee has been appointed and will contribute to the support for all staff including psychiatrists within the city.

Waiting times for the Tayside Adult Autism Consultancy Team remains with increasing waiting time for assessment and support. This is a result of medical shortages. A robust review of the current model is underway. In other parts of the service the Learning Disability and Psychiatry staffing position has improved with substantive post holders now in place.

Care Management Teams

Care Management Teams continue to face significant pressures in undertaking reviews of current care packages and steps are being taken to review the current model of service and skill mix.

Support to Independent Care Homes

The DHSCP Care at Home team have been visiting and providing extra support to independent care home services where concerns were identified.

4. Inspection Reports

Dundee Registered Care Homes for Adults – Care Inspectorate Gradings

The CCPGG considered the above report. This report was previously considered by the Performance and Audit Committee

Kingsway Care Centre

The inspection report was positive and evidenced good practice. The issue of absent observation windows was highlighted again with a recommendation for this be addressed within three months. Work has commenced to install new doors with observation windows.

5. Complaints

The following data has been extracted from Qlikview for Dundee HSCP. This data is collated from Health Systems, and will therefore only reflect part of the Partnership.

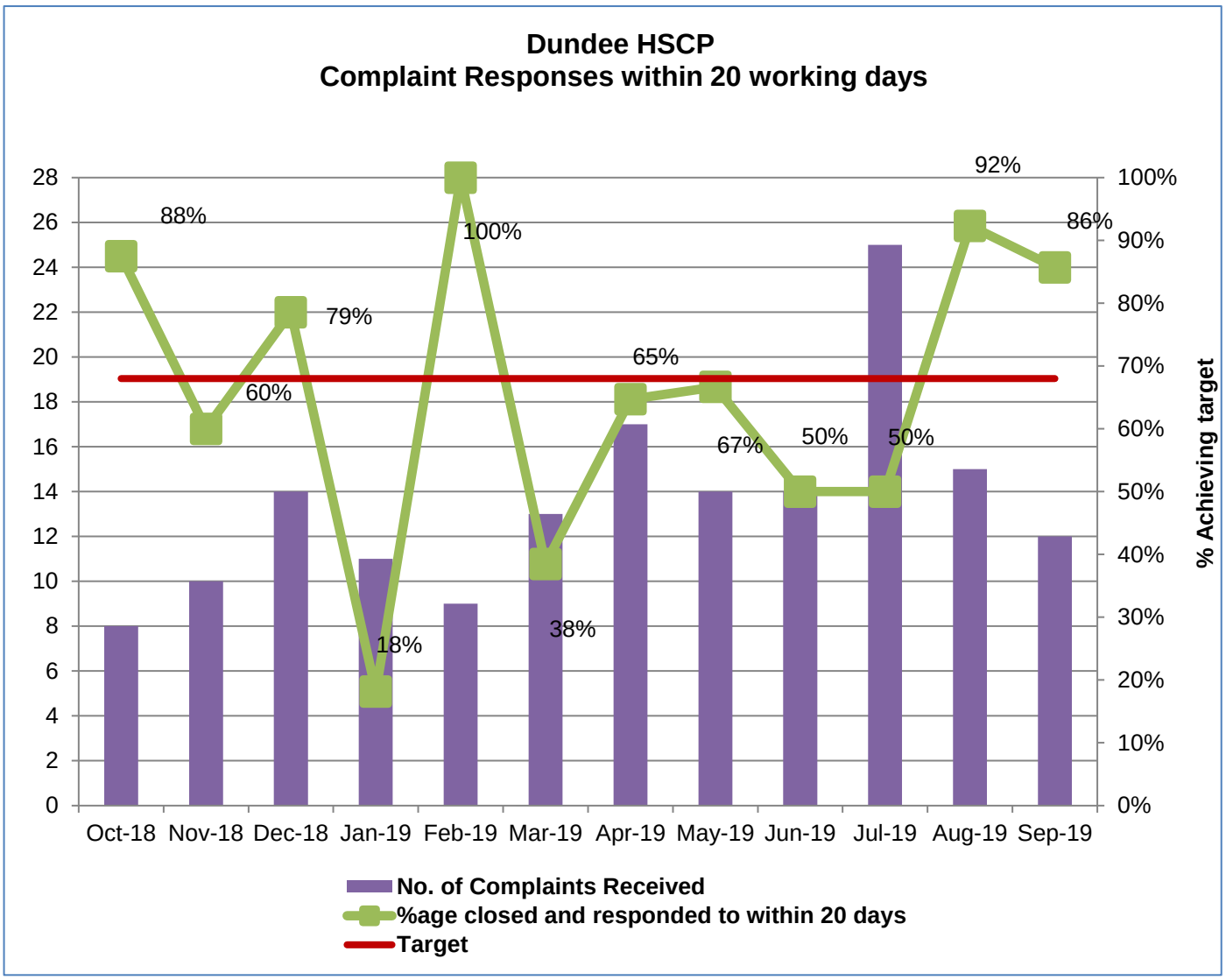


Table 1: Number of NHS Complaints Upheld or Partially Upheld

Year	Source					
	EMAIL	LETTER	OTHER	PERSON	PHONE	SUGG
2017	37	20	1	1	60	1
2018	35	29	-	5	52	-
2019	53	15	-	4	45	-

Discussions on a reporting dataset had identified percentage of NHS complaints upheld or partially upheld. However, this information is only reported on by number within Qlikview, and therefore ongoing discussions will be held to determine the most appropriate reporting parameters.

It was noted that there were a large number of NHST complaints for DHSCP that are overdue. They hadn't previously been reported to the CCPGG because the NHST Complaints and Feedback Team provided information based on complaints that were closed within each quarter. This has now been remedied and open complaints will form part of the reporting framework. DHSCP Social Work complaints continue to be very small in number in comparison to NHST complaints. Going forward reports will be produced relating to the teams so that more detailed inspection of trends can be conducted. Forthcoming reports will include data on open complaints which are over their target dates. Specific areas where there are delays will be reported on.

DCC and NHST complaints officers will continue to work closely together to improve performance.

6. Standards/Legislation/Guidelines

Summary Details of Reported Breaches: February 2019–July 2019

A summary report was presented of all 'Breaches of Confidentiality' within the Datix system reported by Dundee HSCP within the timescales. A system has been set up to automatically notify the Information Governance Team of any data breaches being reported within Datix. Not all records document whether contact with Information Governance has been made, and the outcome of any advice. Within the NHS, the reporting of breaches to the ICO would be made by the Information Governance team. This report will be used to inform training and development for staff in relation to managing and reducing breaches of confidentiality.

Parkinson's Disease Service Development

There is now a Parkinson Disease post discharge multi-disciplinary clinic at Royal Victoria Day Hospital for newly diagnosed patients.

REPORT TO: **PERFORMANCE AND AUDIT COMMITTEE – 26 NOVEMBER 2019**

REPORT ON: **FALLS PERFORMANCE REPORT**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC41-2019**

1.0 PURPOSE OF REPORT

The purpose of this report is to provide assurance that in-depth analysis of falls related hospital admissions in Dundee continues to be progressed and provided to relevant professionals and groups in order to support targeted improvement activities.

2.0 RECOMMENDATIONS

It is recommended that the Performance & Audit Committee (PAC):

2.1 Notes the contents of this report and the analysis of falls related hospital admissions (section 5 and appendix 1).

2.2 Notes the proposed next steps (section 6).

3.0 FINANCIAL IMPLICATIONS

None.

4.0 BACKGROUND INFORMATION

4.1 National Health and Wellbeing Indicator 16 is “Rate of falls related hospital admissions per 1,000 of >65 population”. The focus of this indicator is the number of falls that occur in the population (aged 65 plus). The indicator is measured using data gathered by Information Services Division (ISD).

4.2 This indicator is monitored in the Quarterly Performance Report; local data was included in the Q1 report (Article IX of the minute of the meeting of the Dundee PAC held on 24 September 2019 refers) and local and national data was included in the Annual Performance Report (Article VIII of the minute of the meeting of the Dundee Integration Joint Board Meeting held on 25 June 2019 refers). Both reports highlighted the particularly high rate of hospital admissions within the Dundee population of people aged 65 plus as a result of a fall.

4.3 At Q4 18/19, Dundee had a high rate of hospital admissions as a result of a fall per 1,000 people aged 65 plus. Benchmarking with other Partnerships shows that Dundee had the highest falls rate (30.9) in Scotland and was significantly higher than the Scottish rate of 22.4 admissions as a result of a fall per 1,000 people aged 65 plus. Analysis of falls admissions was presented to the PAC held on 12 September 2017 (Article X of the minute of the meeting refers), with a further analysis being provided to the PAC held on 29 May 2018 (Article IX of the minute of the meeting refers).

4.4 Falls can have a significant impact on an older person's independence and quality of life, impeding a person's mobility and confidence. However, falls are not an inevitable consequence of old age. Well-organised services, delivering recommended and evidence based practices can prevent many falls and fractures in older people in a community setting. Rehabilitation services are key to preventing repeat falls. In addition, the safety of a person's immediate environment as well as a review of their prescribed medicines are important alongside a multifactorial assessment including; eyesight, footwear, foot condition, bone health, nutrition, continence, daily activities and cognition. For every £1 invested in physiotherapy rehabilitation into falls services, £4 is saved across health and social care services (Chartered Society of Physiotherapy).

4.5 A published economic evaluation provided an estimate of the cost to health and social care services in Scotland of managing the consequences of falls is in excess of £470 million and without intervention is set to rise over the next decade as our population ages and the proportion with multi-morbidity and polypharmacy (service users in receipt of multiple drugs to treat conditions) grows. Falls prevention is therefore a priority, both in relation to improve outcomes and quality of life for individual people, their carers and families, but also in relation to supporting the operation of sustainable health and social care services and supports in the future.

4.6 The National Falls and Fracture Strategy is currently at the consultation stage and will be published by the Scottish Government in due course. At the point of publication local falls prevention improvement activity will be reviewed to identify any required adjustments to support alignment with the national strategy.

5.0 WHAT THE DATA IS TELLING US

5.1 To support improvement activity relating to falls a Dundee Falls Data Group was established in August 2019 to develop a detailed understanding of falls related data and its implications for targeting future improvement activity and investment. Part of the work of the group has been to support the Local Intelligence Support Team (LIST) staff, deployed to the Partnership by NSS ISD (National Services Scotland, Information Services Divisions), to undertake an updated in-depth analysis of falls admissions (attached as Appendix 1).

5.2 The main findings from the analysis are:

- As at 2018/19 Dundee had the highest admission rate due to falls in Scotland.
- Coldside, East End and West End are the greatest contributors to the high fall admission rates in Dundee for people aged 65+.
- In 2015/16 one in five fall admissions (21%) had a length of stay of 1 day or less and in 2018/19 this rose to one in three fall admissions (33%).
- For fall admissions with a length of stay of 1 day or less, Angus and Dundee had the highest percentage increases across Scotland between 2015/16 and 2018/19.
- Ninewells Hospital had the highest percentage increase of fall admissions of all the Acute General Hospitals in Scotland between 2015/16 and 2018/19.
- The 80-89 age group, females in particular, has seen the largest increase in fall admissions between 2015/16 and 2018/19. Both admissions due to falls, where no medical procedure was required and admissions due to falls where a medical procedure was required have increased for this age group.
- Coldside had the highest admission rate due to falls, where no medical procedure was required, for people aged 80-89 for 3 of the last 4 years.
- West End had the highest admission rate due to falls where a medical procedure was required, for people aged 80-89 for the last 3 years.

6.0 NEXT STEPS

6.1 The updated falls analysis (Appendix 1) will now be further developed, with a particular focus on:

- Testing a hypothesis that the transfer of patients from the Emergency Department to a very short stay observation unit has contributed to the increase in falls related admissions.
- Comparing the falls pathways and falls related admissions in Dundee (which does not have a Minor Injury Unit) to a Partnership which has a Minor Injury Unit.
- Further analysing the fall related hospital admissions lasting 1 day or less, where no medical procedure was required.

6.2 This further analysis and findings will be presented to the Dundee Falls Data Group to assist discussions regarding service development and improvement. It will also be shared with relevant professionals to assist their understanding of falls prevention.

7.0 RISK ASSESSMENT

Risk 1 Description	The risk of not reducing the rate of hospital admissions due to a fall could affect; outcomes for individuals and their carers and spend associated with unscheduled hospital admissions if the Partnership's performance does not improve.
Risk Category	Financial, Governance, Political
Inherent Risk Level	Likelihood 3 x Impact 5 = Risk Scoring 15
Mitigating Actions (including timescales and resources)	- The in depth analysis included in this paper and appendix will be used to inform senior managers. - The Tayside Falls Prevention and Management Framework will provide an infrastructure to monitor progress in the community, hospital and care homes towards preventing the incidence of falls and reducing the negative effect of falling on people who fall and their carers. - The priority areas for improvement (section 8.0) have been developed to reduce the rate of hospital admissions as a result of a fall.
Residual Risk Level	Likelihood 3 x Impact 3 = Risk Scoring 9
Planned Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6
Approval recommendation	The risk level should be accepted with the expectation that the mitigating actions are taken forward.

8.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment and Risk Management. There are no major issues.

9.0 CONSULTATIONS

The Chief Officer, Head of Service - Health and Community Care and the Clerk were consulted in the preparation of this report.

10.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

DATE: 15 November 2019

Stephen Halcrow and Elizabeth Balfour
Local Intelligence Support Team
ISD Scotland

APPENDIX 1

Falls Report for Dundee H&SCP

By Liz Balfour and Stephen Halcrow

Release date: 30/10/2019

Local Intelligence Support Team (LIST) Report

NHS National Services Scotland

Table of Contents

Introduction

This report has been prepared by the Local Intelligence Support Team (LIST) on behalf of Dundee Health & Social Care Partnership in order to better understand unscheduled care activity.

This report aims to show how Dundee H&SCP compares to Scotland and other partnerships for fall admissions for those over 65 years of age with regards to length of stay, patient demographics and admissions with and without recorded procedures.

Data Sources

The data used for this report is taken from the SMR01 national dataset and trend data shows annual trend data from 2015/16 to 2018/19.

Main Points

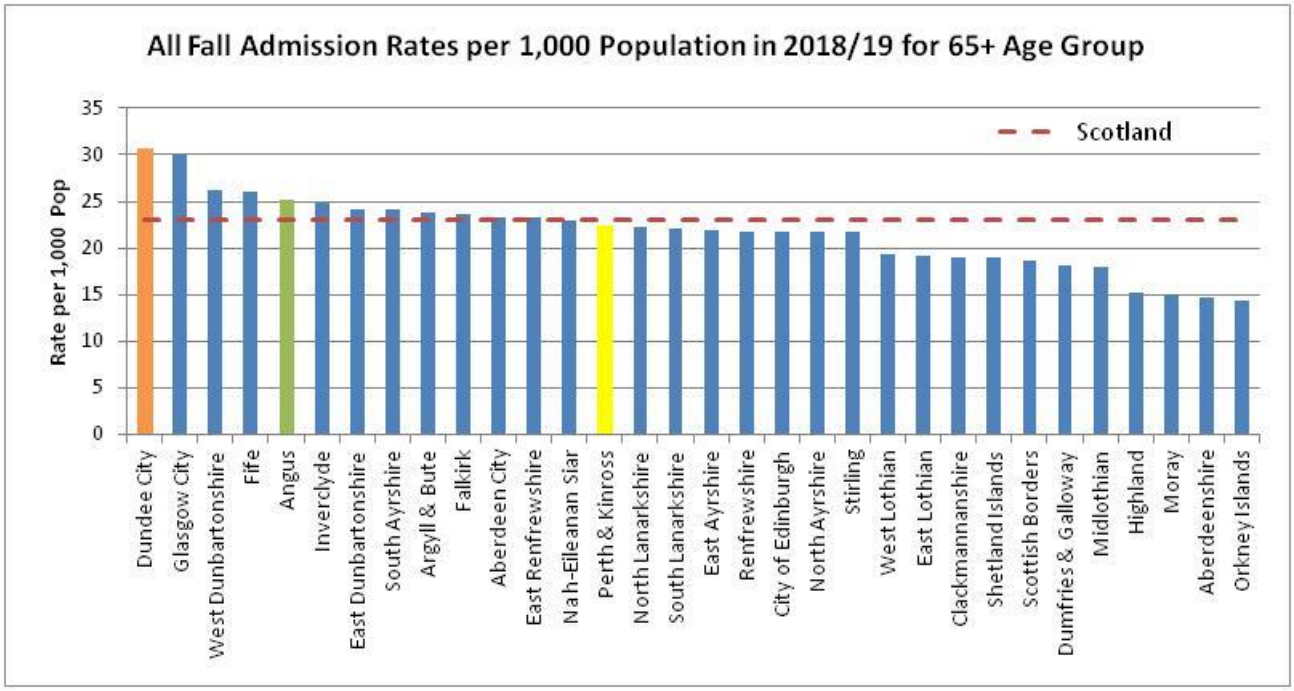
- As at 2018/19 Dundee had the highest fall admission rates in Scotland
- Coldside, East End and West End seem to be driving the high fall admission rates in Dundee for people aged 65+
- In 2015/16 one in five fall admissions (21%) had a length of stay of 1 day or less and in 2018/19 this rose to one in three fall admissions (33%)
- For fall admissions with a length of stay of 1 day or less, Angus and Dundee have the highest percentage increases across Scotland between 2015/16 and 2018/19
- Ninewells Hospital has the highest percentage increase of fall admissions of all the Acute General Hospitals in Scotland between 2015/16 and 2018/19
- The 80-89 age groups have seen the largest increase in fall admissions between 2015/16 and 2018/19 and in particular females. Both falls with no procedures and falls with procedures have increased for this age group.
- Coldside has had the highest fall admission rate, for falls with no procedures, for people aged 80-89 for 3 of the last 4 years
- West End has had the highest fall admission rate, for falls with procedures, for people aged 80-89 for the last 3 years

Analysis

Fall Admission Rates per 1,000 Population for 65+

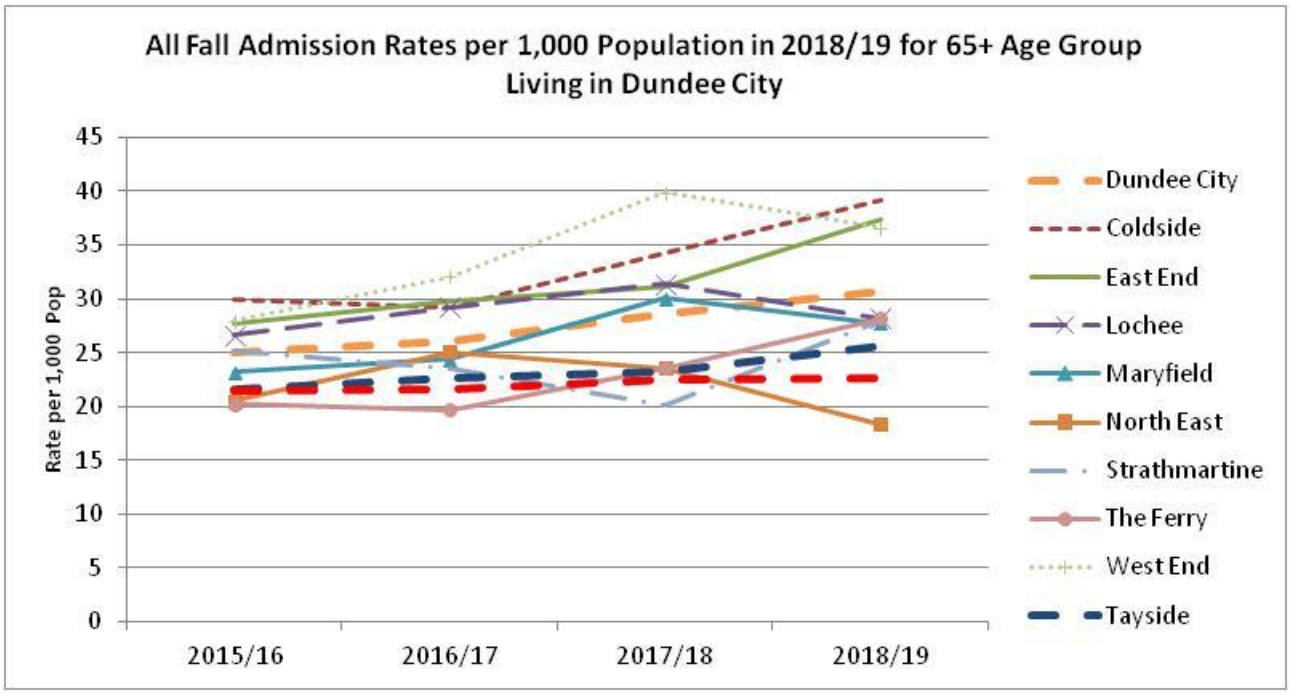
In 2018/19 Dundee City has the highest falls rate with 31 per 1,000 population for people aged 65+ years. Three localities in particular seem to be driving the falls admission rate in Dundee; Coldside, East End and West End. Dundee also has one of the highest percentage change increases in Scotland between 2015/16 and 2018/19 for the number of fall admissions, with around a 5% increase (Angus has the second highest with a 6% increase).

Figure 1.1 – All Fall Admission Rates per 1,000 Population in 2018/19 for 65+ Age Group by Partnerships



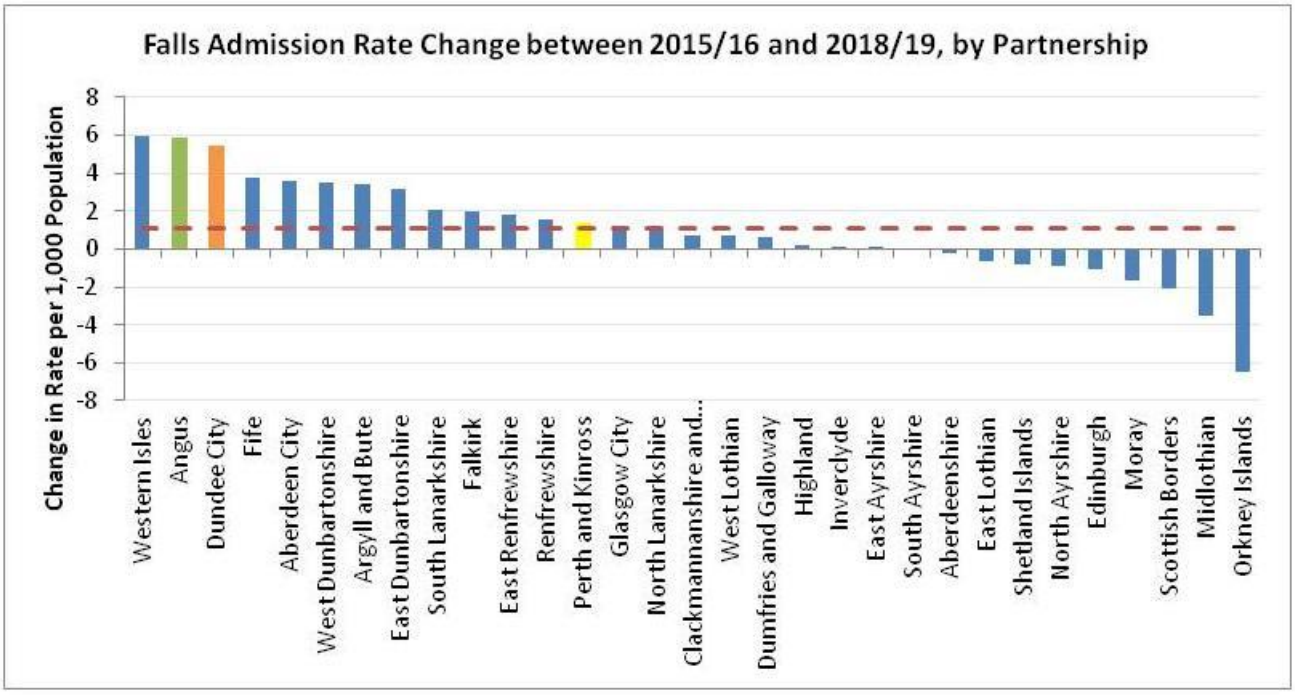
Source: ISD Scotland SMR01

Figure 1.2 – All Fall Admission Rates per 1,000 Population in 2018/19 for 65+ Age Group Living in Dundee City



Source: ISD Scotland SMR01

Figure 1.3 – Fall Admission Rate Change between 2015/16 and 2018/19 by Partnerships

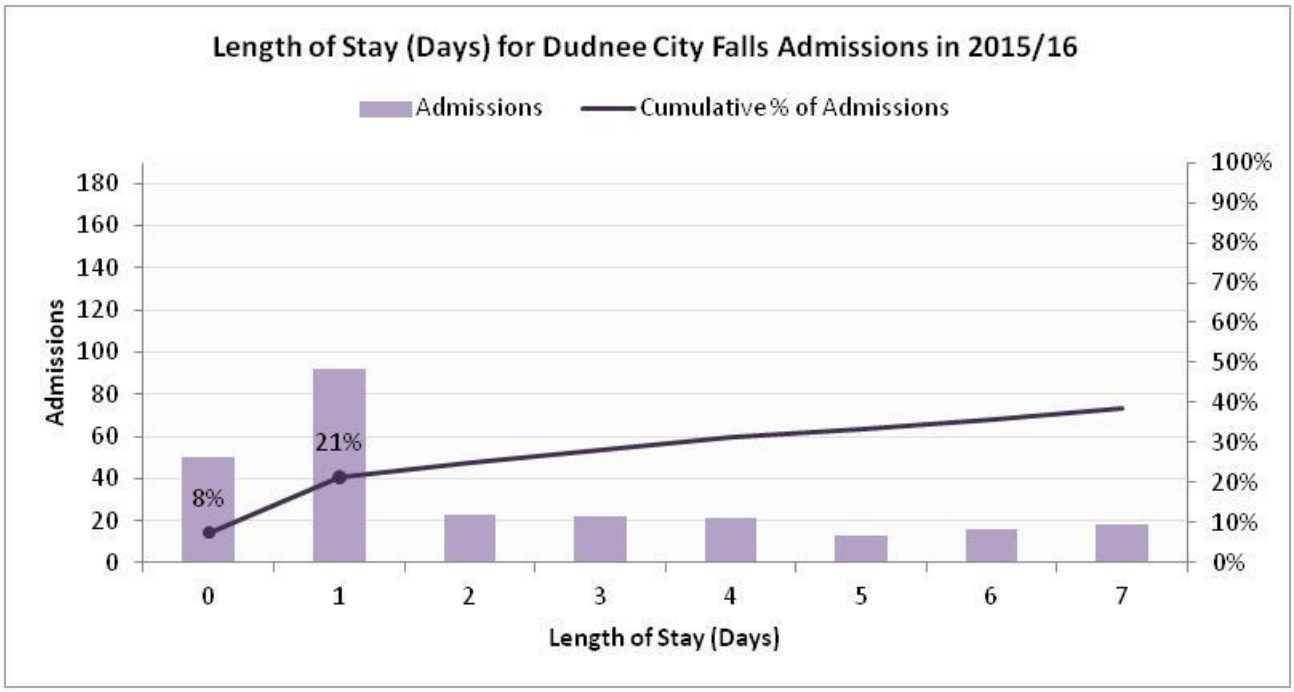


Source: ISD Scotland SMR01

Short Stays

The proportion of fall admissions with a length of stay 1 day or less rose in Dundee from 21% in 2015/16 to 33% in 2018/19. Both Angus and Dundee have the two highest fall admission numbers with a length of stay 1 day or less between 2015/16 and 2018/19 with 14.5% and 11.6% respectively. When shown by acute hospitals across Scotland, then Ninewells has the highest increase in short stay fall admission numbers from 20% of all fall admissions in 2015/16 to 33% of all fall admissions in 2018/19. Of all short stay fall admissions, around 89% of these have no procedures.

Figure 2.1 – Length of Stay (Days) for Dundee City Falls Admissions in 2015/16



Source: ISD Scotland SMR01

Figure 2.2 – Length of Stay (Days) for Dundee City Falls Admissions in 2018/19 in Dundee City

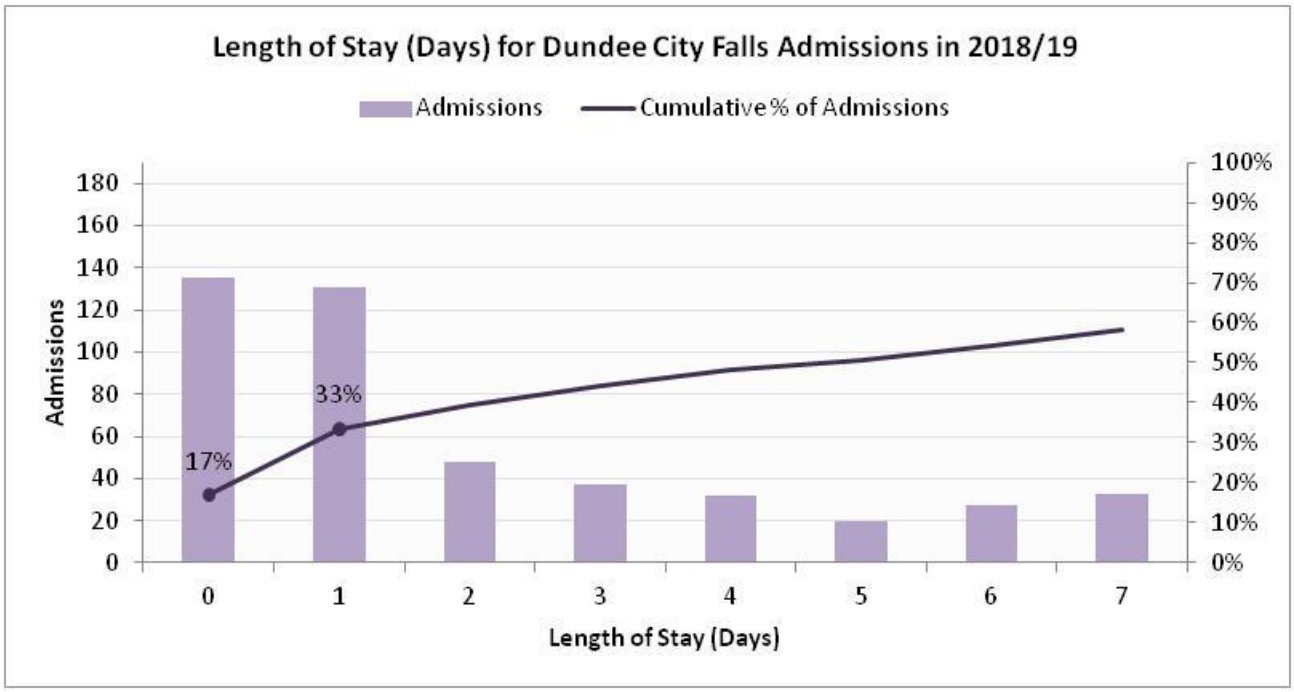
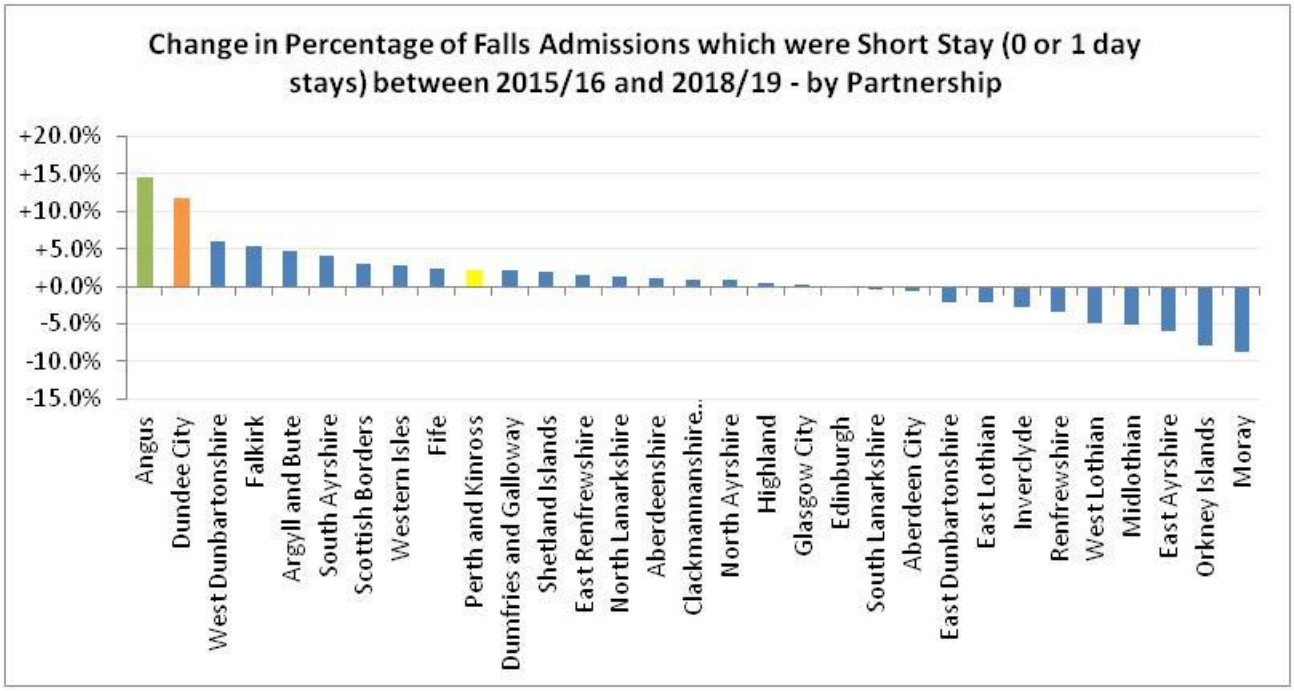
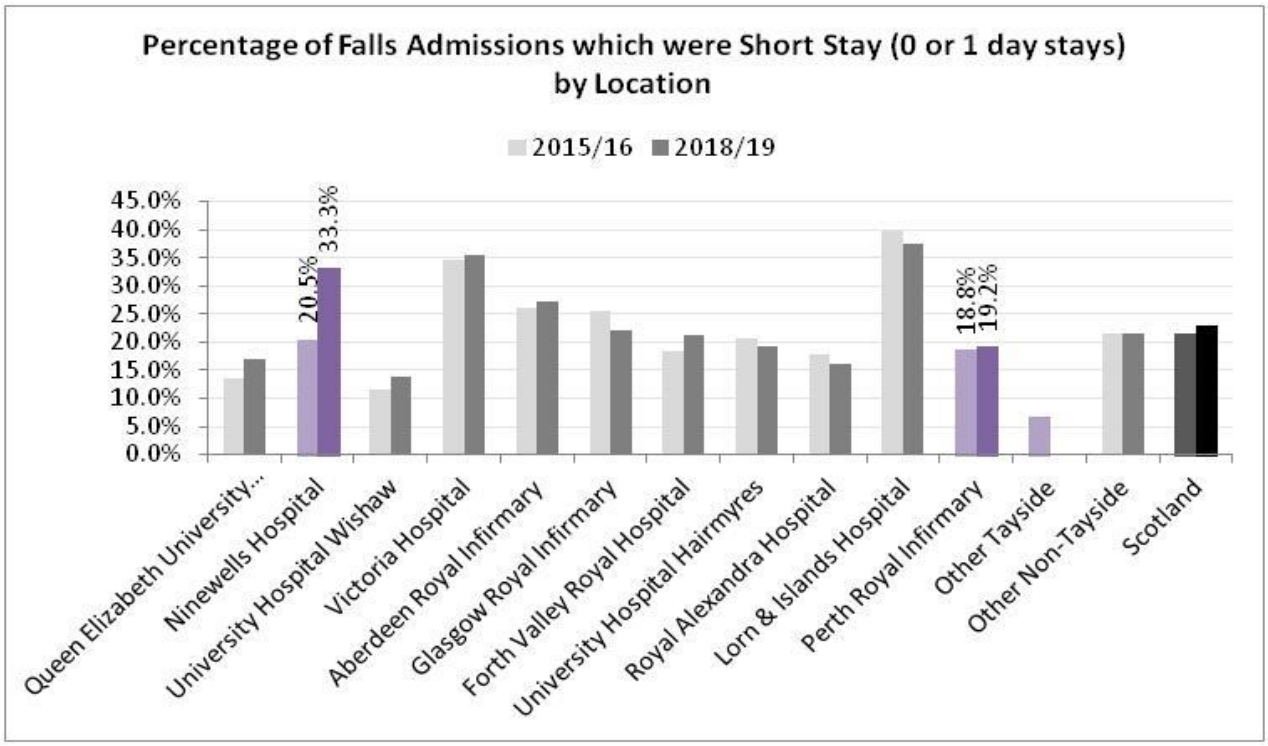


Figure 2.3 – Change in Percentage of Falls Admissions which were Short Stay (0 or 1 day Stays) between 2015/16 and 2018/19 by Partnerships



Source: ISD Scotland SMR01

Figure 2.4 – Percentage of Falls Admissions which were Short Stay (0 or 1 day stays) by Location



Source: ISD Scotland SMR01

Age Groups

The biggest increase in fall admission rates in Dundee City between 2015/16 and 2018/19 was seen in the 80-84 and 85-89 year age groups. All other age groups aged 65+ were relatively static during this period. It was women who were the biggest driving factor in the fall admission increase for the 80-89 age group. For the short stay fall admissions all age groups above the age of 65 saw an increase in admissions between 2015/16 and 2018/19 whereas for the 2+ length of stay admissions it was only the 80-89 year old people that saw a noticeable increase.

Figure 3.1 – Falls Rate per 1,000 Population in Dundee City by Age Group

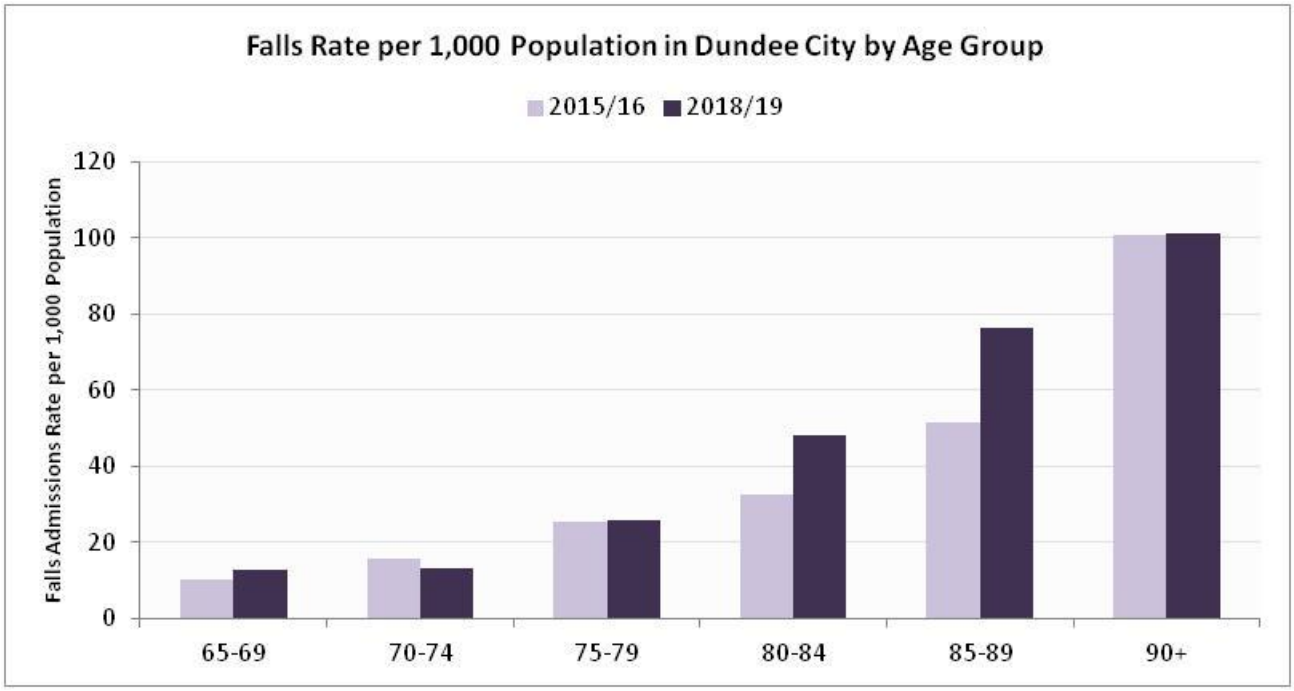
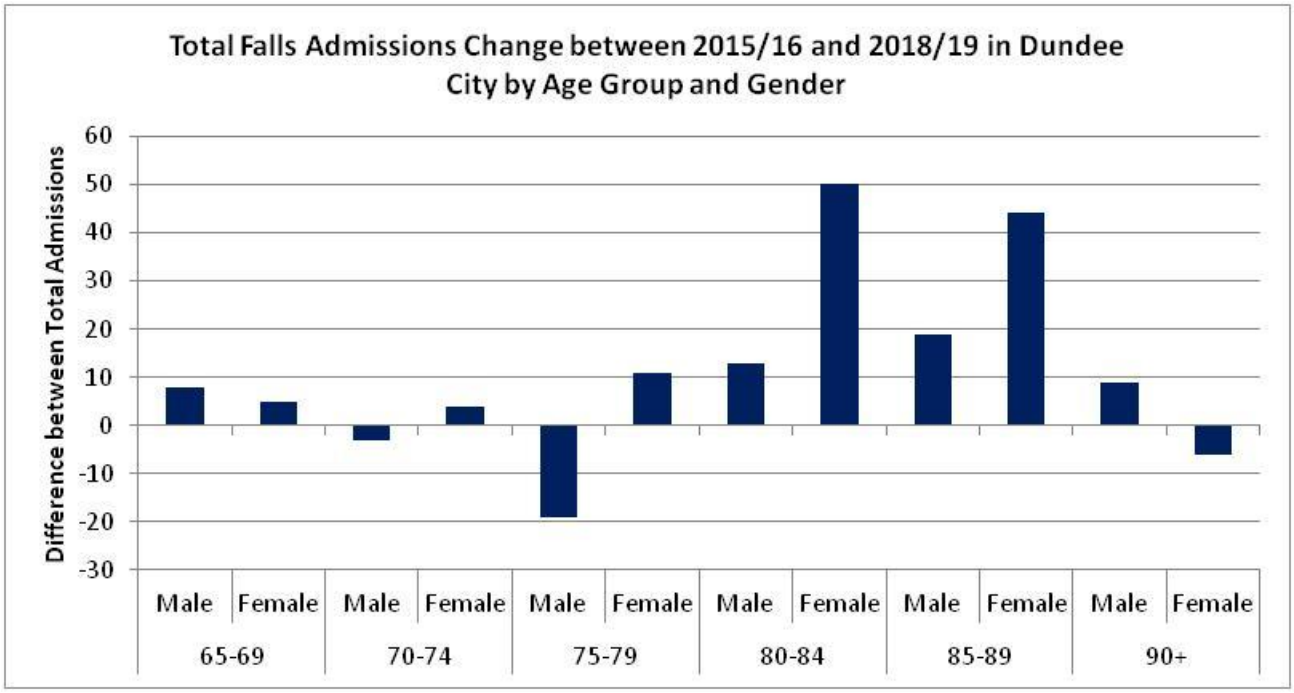


Figure 3.2 –Total Falls Admissions Change between 2015/16 and 2018/19 in Dundee City by Age Group and Gender



Source: ISD Scotland SMR01

Figure 3.3 – Falls Rate per 1,000 Population in Dundee City by Age Group which were Short Stay (0 or 1 day stays)

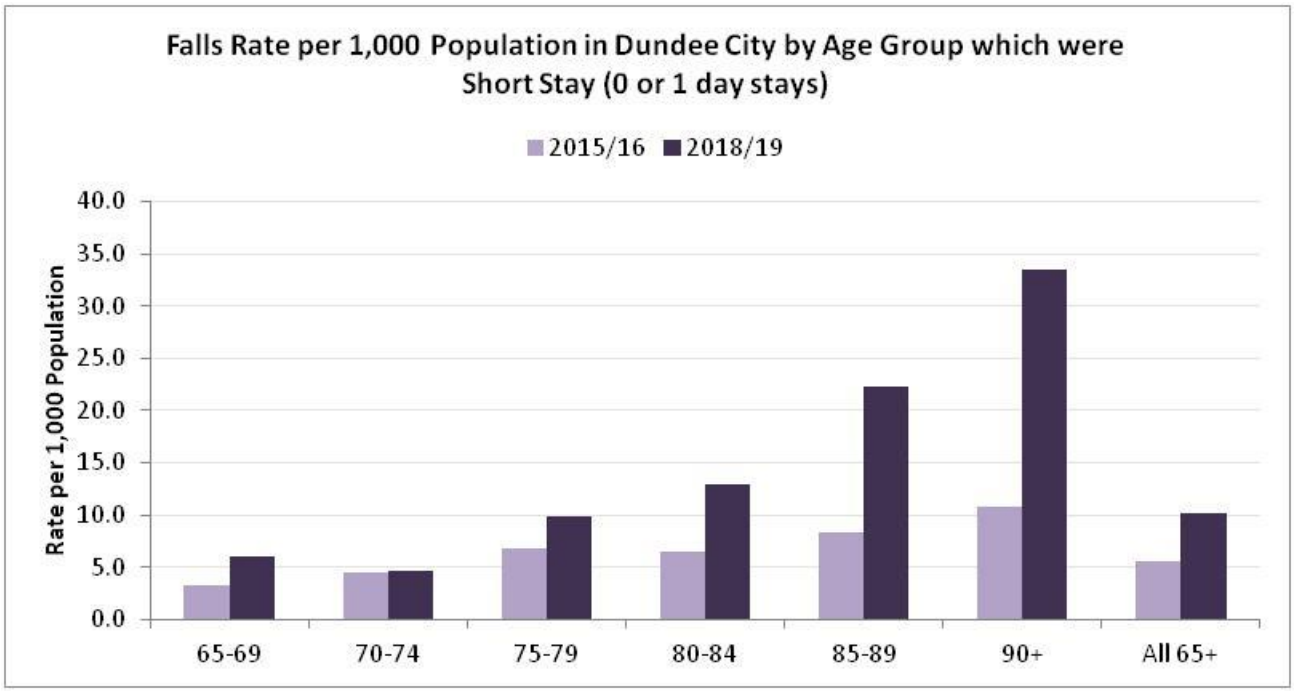
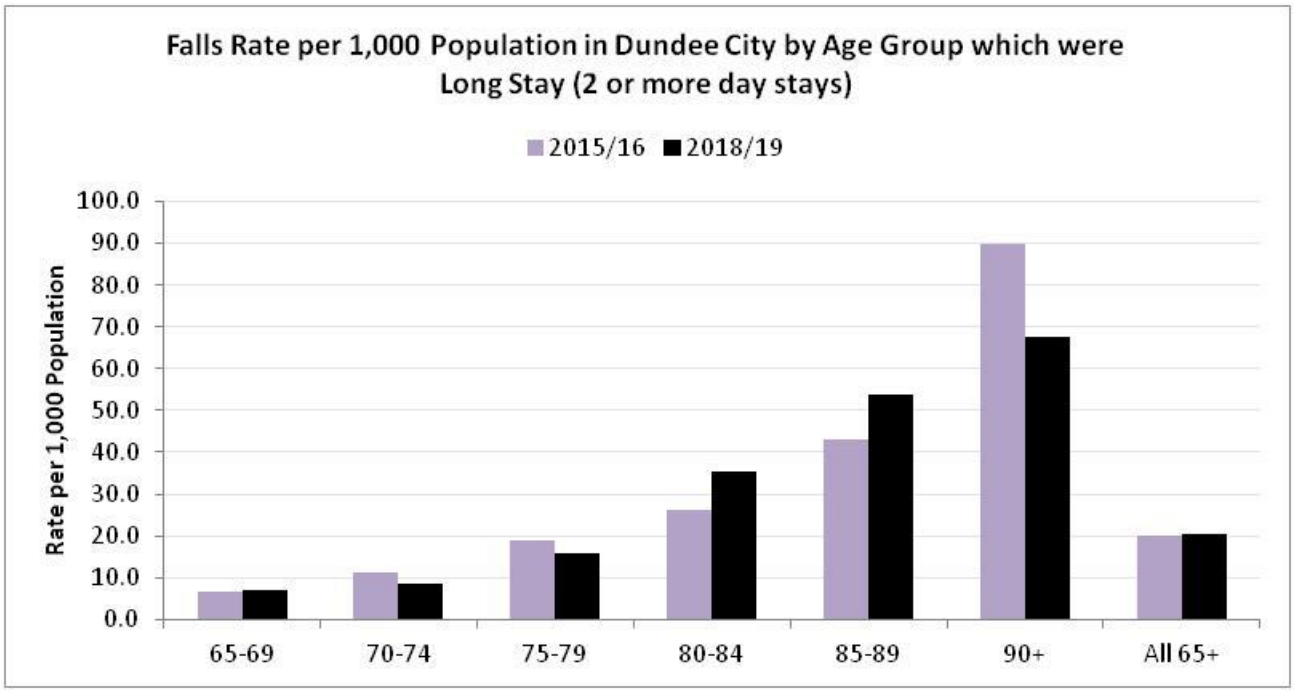


Figure 3.4 – Falls Rate per 1,000 Population in Dundee City by Age Group which were Long Stay (2 or more day stays)

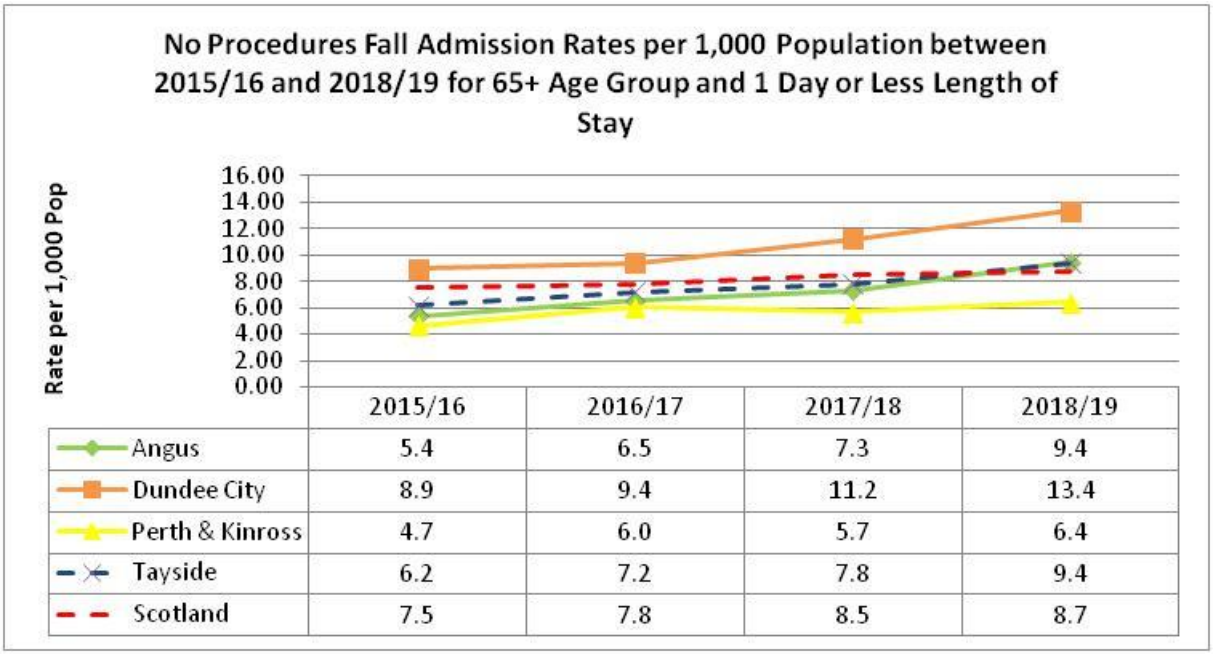


Source: ISD Scotland SMR01

Fall Admission (with no procedures) Rates per 1,000 Population for 65+ Age Groups with 1 Day or Less Length of Stay

Dundee fall admission rates, with no procedures and length of stay of 1 day or less, for people age 65+ have continually increased since 2016/17. The two localities that have the highest rates are Coldside and East End.

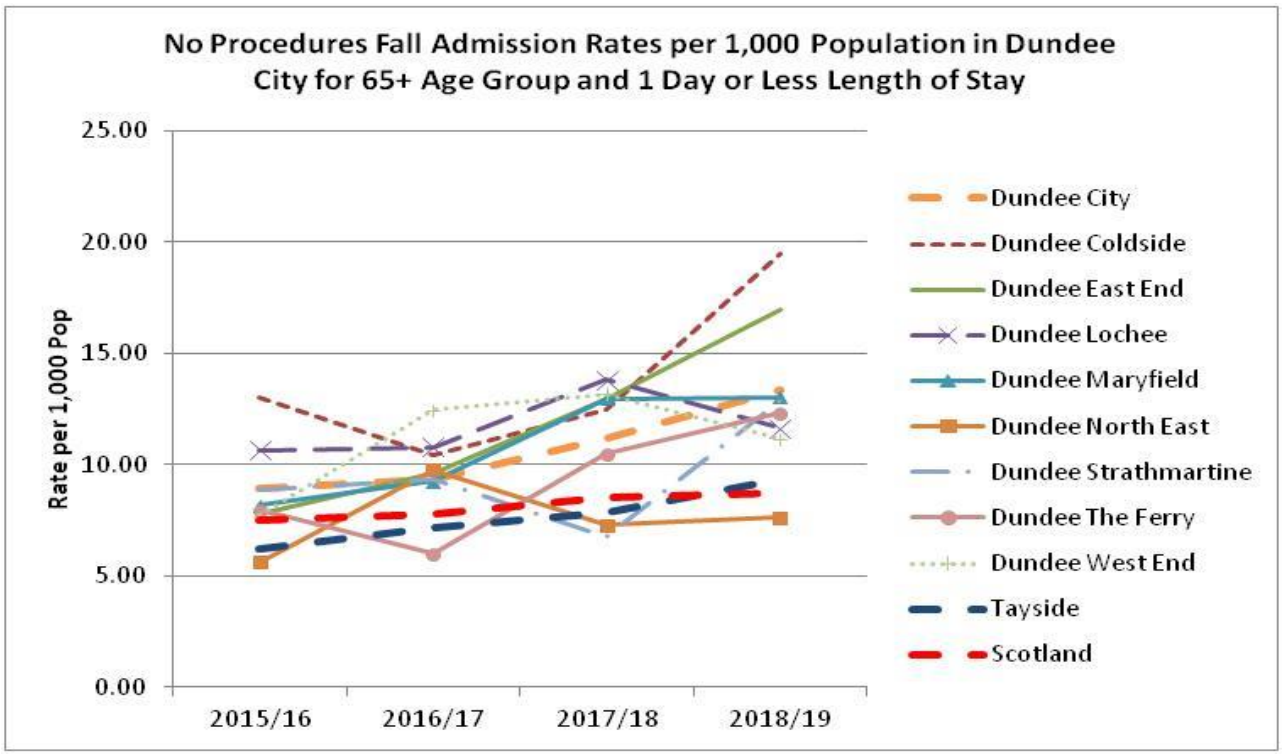
Figure 4.1 – All Falls Admission (with no procedures) Rates per 1,000 Population for 65+ Age Group with 1 Day Length of Stay by Tayside Partnerships between 2015/16 and 2018/19



	2015/16	2016/17	2017/18	2018/19
Angus	5.4	6.5	7.3	9.4
Dundee City	8.9	9.4	11.2	13.4
Perth & Kinross	4.7	6.0	5.7	6.4
Tayside	6.2	7.2	7.8	9.4
Scotland	7.5	7.8	8.5	8.7

Source: ISD Scotland SMR01

Figure 4.2 – All Falls Admission (with no procedures) Rates per 1,000 Population for 65+ Age Group with 1 Day Length of Stay by Dundee Localities between 2015/16 and 2018/19



Source: ISD Scotland SMR01

Fall Admission Rates per 1,000 Population for 80-89 Age Groups

Dundee has the highest fall admission rates for people aged 80-89 with 60 per 1,000 population. As with the 65+ population, Coldside, East End and West End are driving these rates up, but also Strathmartine rates are amongst the highest in Dundee. For fall admissions with no procedures Coldside has had the highest rates for 3 of the last 4 years. For fall admissions with procedures the West End that has had the highest rates for the last 3 years.

Figure 5.1 – All Falls Admission Rates per 1,000 Population in 2018/19 for 80-89 Age Group by Partnership

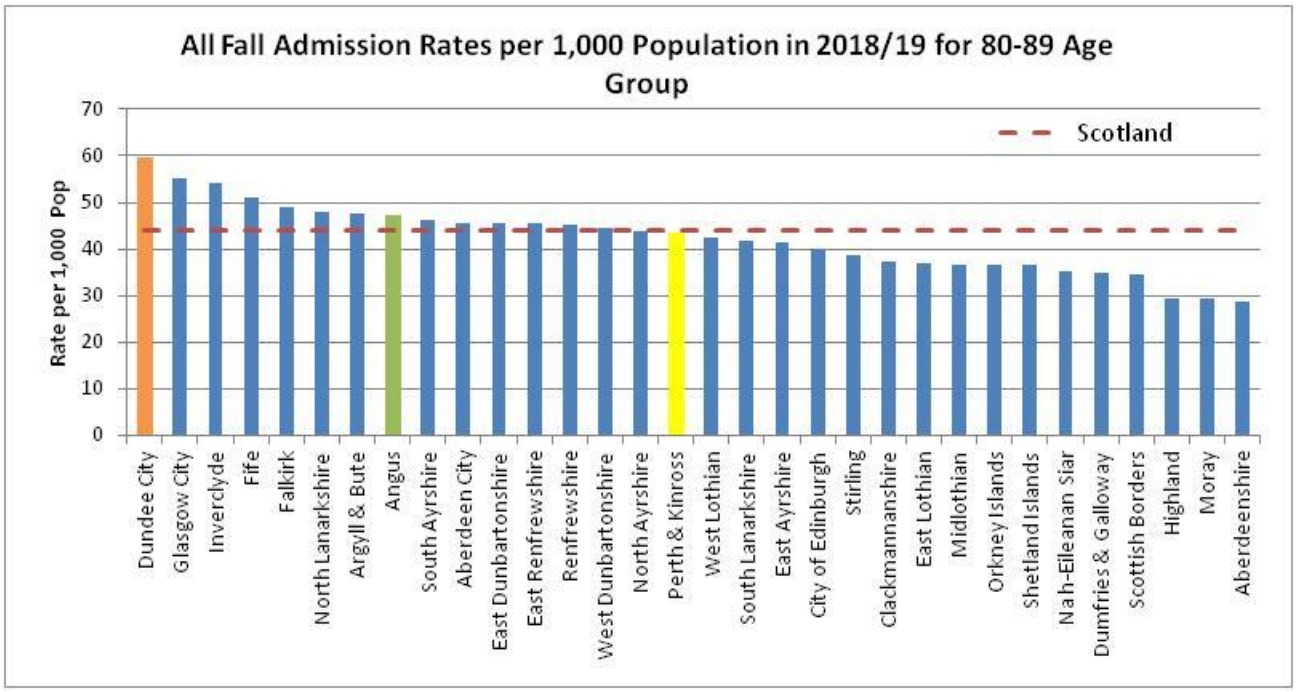
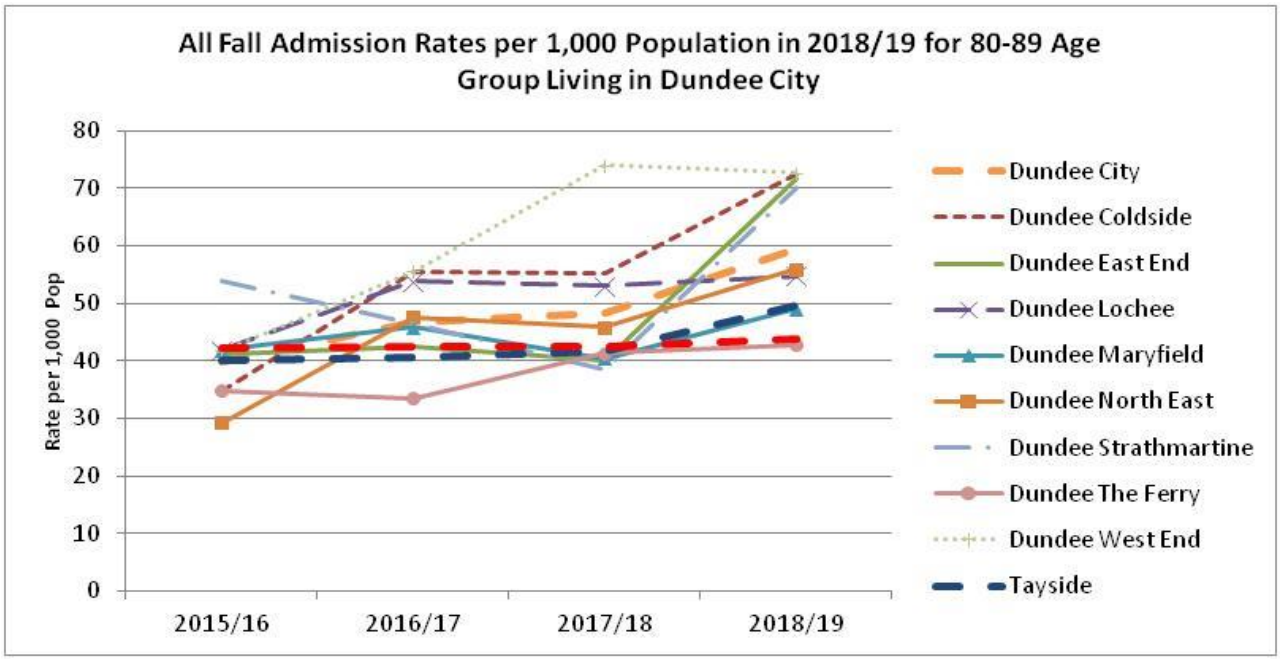


Figure 5.2 – All Falls Admission Rates per 1,000 Population in 2018/19 for 80-89 Age Group Living in Dundee City



Source: ISD Scotland SMR01

Figure 5.3 – All Falls (with no procedures) Admission Rates per 1,000 Population in 2018/19 for 80-89 Age Group Living in Dundee City with 1 Day or Less Length of Stay

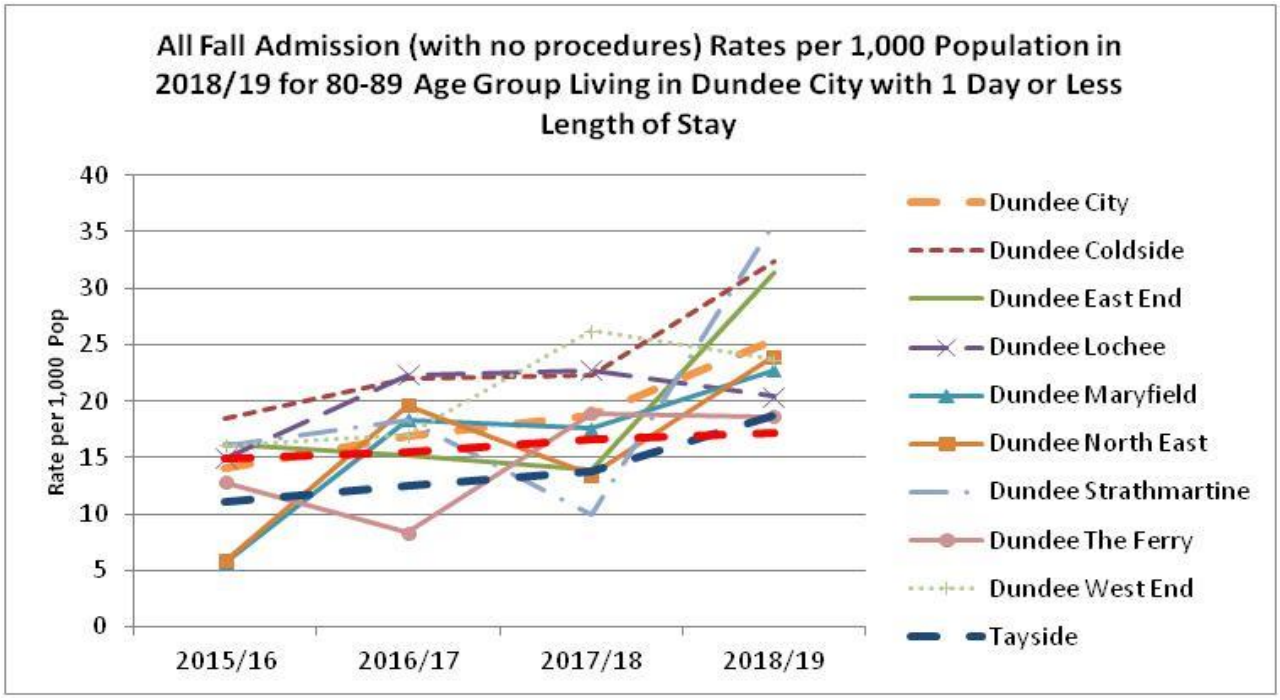
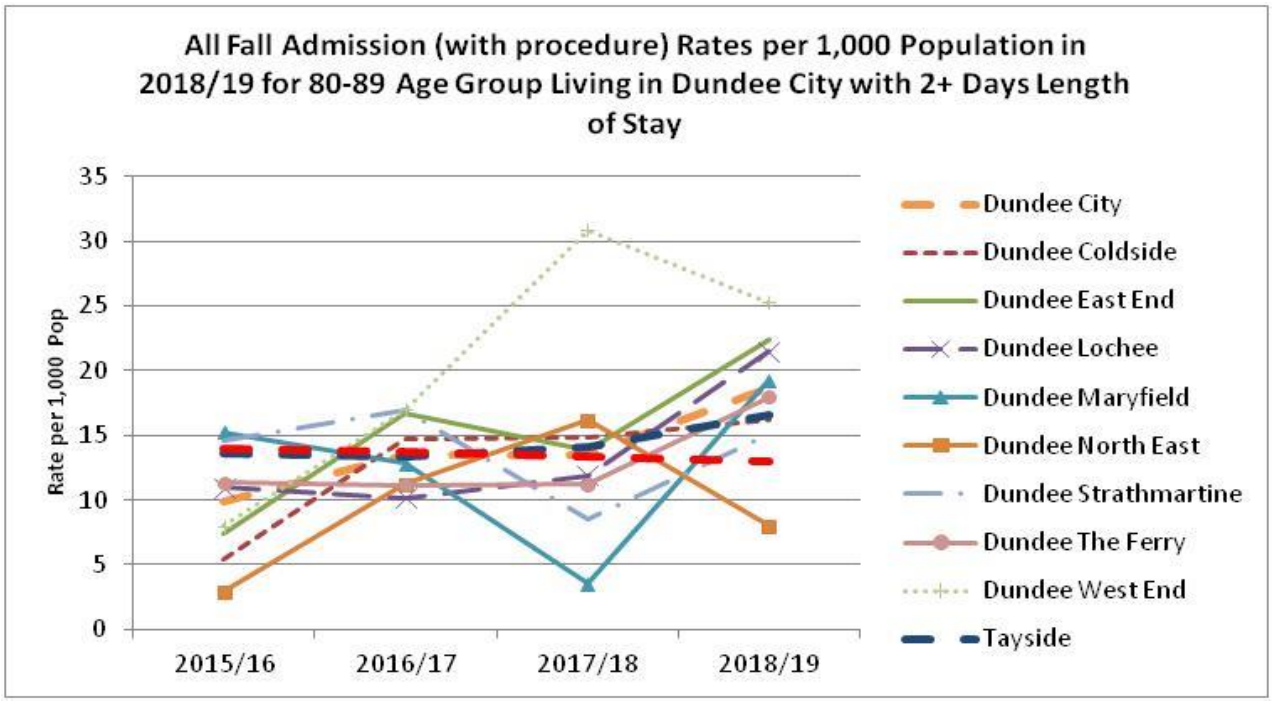


Figure 5.4 – All Falls (with a procedure) Admission Rates per 1,000 Population in 2018/19 for 80-89 Age Group Living in Dundee City with 2+ Days Length of Stay



Source: ISD Scotland SMR01

Primary Diagnoses for Fall Admissions in Dundee Residents aged 65+

Figure 6.1 – Primary Diagnoses for Fall Admissions, with a Length of Stay Equal to 1 Day or Less, in Dundee Residents aged 65+

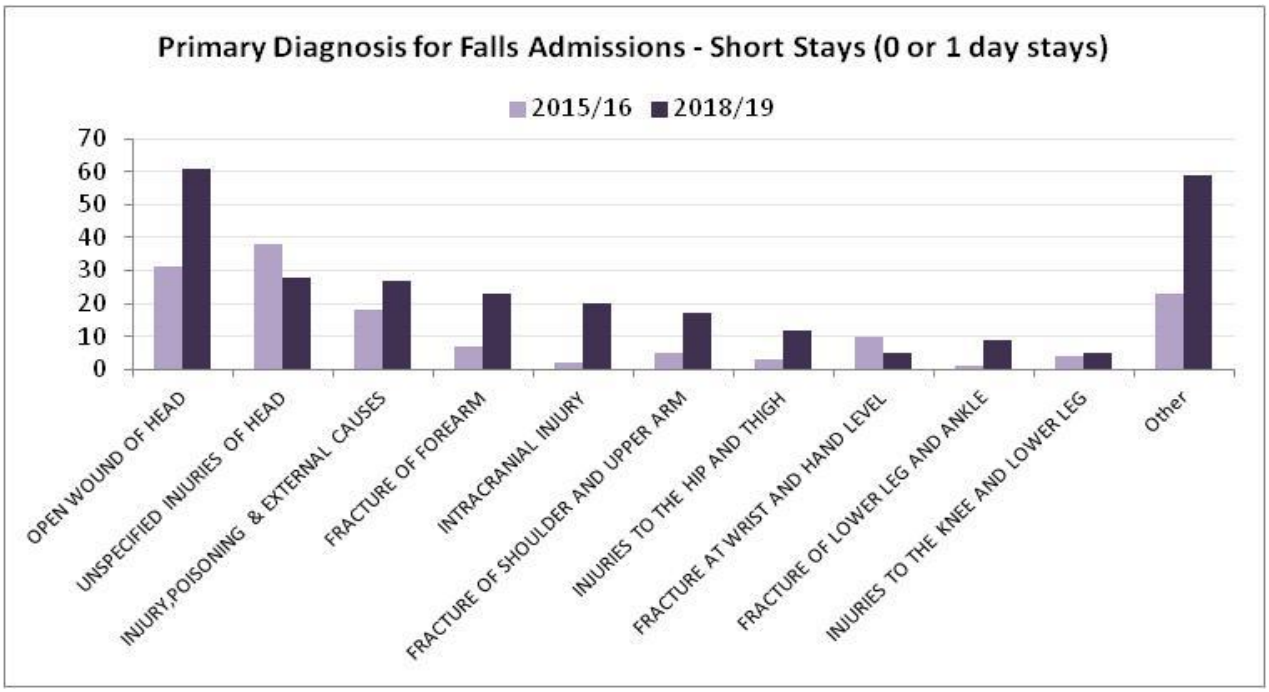
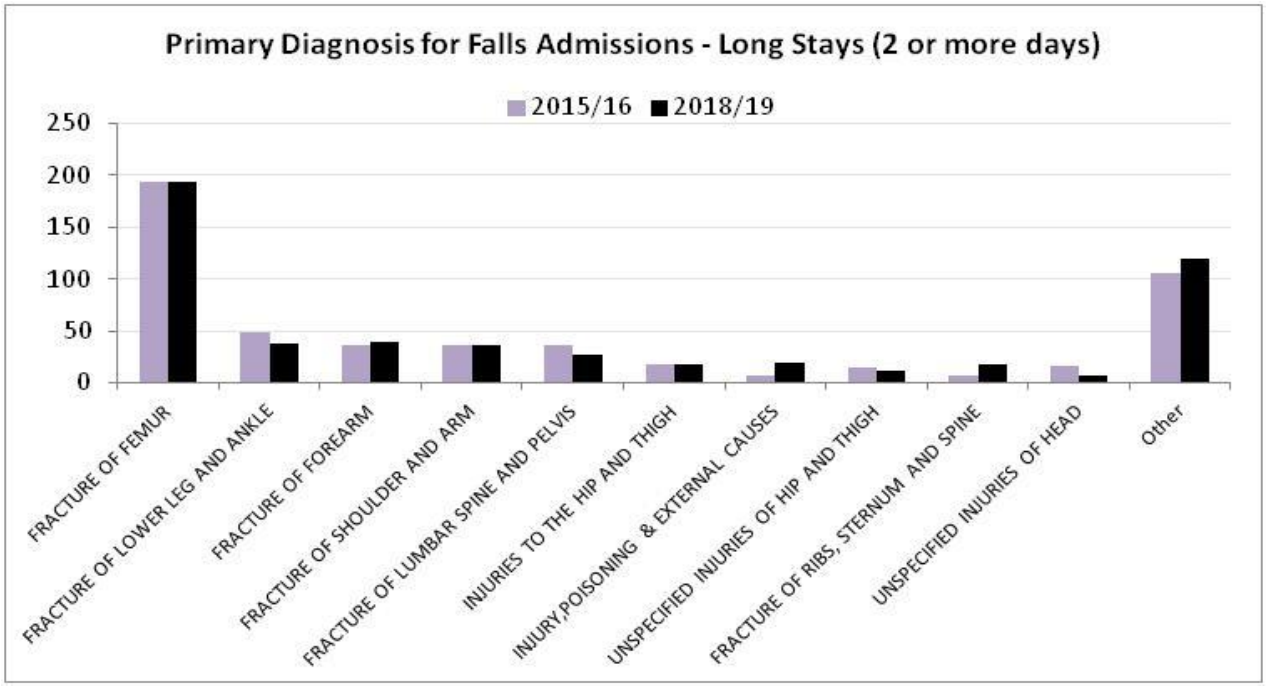


Figure 6.2 – Primary Diagnoses for Fall Admissions, with a Length of Stay of 2+ Days, in Dundee Residents aged 65+



Source: ISD Scotland SMR01

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ITEM No …7…

REPORT TO: **PERFORMANCE AND AUDIT COMMITTEE – 26 NOVEMBER 2019**

REPORT ON: **GOVERNANCE ACTION PLAN PROGRESS REPORT**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC42-2019**

1.0 PURPOSE OF REPORT

The purpose of this report is to provide the Performance and Audit Committee with an update on the progress of the actions set out in the Governance Action Plan.

2.0 RECOMMENDATIONS

It is recommended that the Performance and Audit Committee (PAC):

2.1 Notes the progress made in relation to the actions set out in the Governance Action Plan as outlined in Appendix 1.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

4.1 The Governance Action Plan was presented and approved at the PAC meeting of the 25th March 2019 (Article VIII of the minute of the meeting refers) in response to a recommendation within Dundee Integration Joint Board's Annual Internal Audit Report 2017/18. This action plan enables the PAC to regularly monitor progress in implementing actions and understands the consequences of any non-achievement or slippage in strengthening its overall governance arrangements. The PAC remitted the Chief Finance Officer to present an update progress report to each PAC meeting. This action plan has also been added to in order to reflect a range of actions arising from the recent Audit Scotland Annual Report 2018/19 for Dundee Integration Joint Board. The progress of the actions is noted in Appendix 1.

4.2 Members of the PAC will note a delay in progressing a range of actions as set out in the report. This includes actions to be addressed through the updated Workforce and Organisational Development Plan which was not presented to the IJB in August as originally planned. This and other delays have been due to challenges in meeting a range of priorities with limited resources available to progress within the Health and Social Care Partnership. Progress is being made in strengthening the support structure and realign priorities to ensure these actions are completed over the course of this financial year. While the delay in progressing a number of improvement actions has been noted by both internal and external audit, this has not resulted in significant concerns as to the IJB's overall governance arrangements and systems of control.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment and Risk Management. There are no major issues.

6.0 RISK ASSESSMENT

This report has not been subject to a risk assessment as it relates to the development of an action plan in line with the findings of the Annual Internal Audit Report.

7.0 CONSULTATIONS

The Chief Officer, Chief Internal Auditor and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

DATE: 15 November 2019

Performance and Audit Committee Report	Audit Recommendation	Agreed Action	Original Action By / Date	**Red: Not Started Amber: In Progress Green : Complete**	Remedial Action/Comments	Revised Target Completion Date
Dundee Integration Joint Board Clinical, Care and Professional Governance Internal Audit Review *(PAC9-2018)* *13th February 2018*	A review should be undertaken to establish or update the remits of the PAC, R2 and Forum in relation to clinical and care governance. The remits should set out reporting lines and be translated into annual work plans for each group. This should ensure reports, both for the purpose of assurance as well as for implementation or delivery, go to the most appropriate group.	Undertake review as outlined in the Audit Recommendations, setting out the remits of the PAC, R2 and Forum, and the reporting lines between all three. This process should also be followed for the Mental Health Governance Group to ensure appropriate lines of communication into the DHSCP governance processes.	Lead Allied Health Professional (Forum) Clinical Director (R2) Chief Finance Officer (PAC) Associate Nurse Director - Mental Health and Learning Disabilities 31 March 2018	**AMBER**	*Review of the CCPG forum and the CCPG Group has led to the development of primary governance groups under each locality manager. Each Primary Governance Group is to report directly into the CCPG Group. Terms of reference are in development for the primary governance groups, which link directly through CCPG Group and Clinical Quality Forum ensuring assurance process from service level to CQF. CCPG Forum will continue to operate as an avenue for service managers to share good practice and have dedicated*	March 2020

					space to discuss challenges across the Partnership.	
	A particular focus should be given to the level and nature of data to be provided at each level. This should include consideration of the fact that groups may need related information to provide context and allow triangulation.	Produce (review) Terms of Reference to define the governance arrangements including clear reporting between each group.	Lead Allied Health Professional / Head of Service, Health and Community Care 31 March 2018	**GREEN**		N/A
	In addition to the 6 domains of clinical and care governance across delegated services, this review of remits needs to give consideration to: - Hosted services - Information Governance - Care Commission reports - Risk	Clarify and agree datasets and information to be presented at each group and associated timescales to ensure coordination of governance process.	Lead Allied Health Professional / Head of Service, Health and Community Care 30 June 2018	**AMBER**	A reporting table has been developed in the Dundee Partnership outlining the expectation and reporting detail across different groups. This reporting table has been adopted by all three Partnerships. The Getting it Right for Everyone – A CCPG Framework is currently under review with a cross Tayside working group. This group is building on work already completed on reporting datasets which includes inspections reports, risks, adverse events etc.	December 2019
	It is recommended that any new arrangements be	The IJB will formally request that the Chair of the R1	Chief Officer	**AMBER**	*Working group established at Tayside*	~~October 2019~~ February 2020

	considered and approved by the IJB or a nominated Committee/group.	Group advise the IJB of performance of R1 and any new arrangements to be implemented. Chief Officer of DIJB to clarify reporting arrangements between R1 and IJB. Regular representation at the R1 and CQF will be provided from the R2 Group.	Lead Allied Health Professional / Head of Service, Health and Community Care 31 July 2018 (To allow time for R1 meetings to run)		*level which will support and clarify reporting arrangements.* *A regular report is provided to the CQF and the Head of Service and/or Lead AHP attend to speak to the report at each meeting.*	
	Work undertaken to map out the assurance routes for the key domains should be further augmented by a mapping to the functions set out in the Appendix to the Integration Scheme, setting out all delegated functions, with priority given to the areas of highest importance/risk.	Integration scheme delegated functions will be mapped to ensure forum membership reflects the breadth of delegated functions. Service reports and performance data will reflect the breadth of the delegated functions ensuring that reports to the IJB also reflect the breadth of the delegated functions.	Lead Allied Health Professional / Head of Service, Health and Community Care 30 April 2018	**AMBER**	*Programme reporting covering all services will all be completed by June 2019.* *Schedule of services confirmed and membership extended to ensure all areas are considered by the R2 group* *The development of the Primary Governance Groups will ensure comprehensive reporting across all aspects of the Partnership. There are a number of anomalies with some teams sitting outwith Locality Manager structures and these teams will report*	March 2020

					directly to CCPG Group. *Further work to identify core and service datasets is ongoing, locally for DHSCP and across Tayside via the Getting it Right for Everyone Review Group.*	
	Work should be undertaken on establishing a consistent assurance appetite to ensure that the level of assurance received is consistent across all clinical and care governance domains across all services commensurate with the level of risk each represents (e.g. an understanding of falls might be equally appropriate in both hospital and community care settings). Agreed levels of reporting should be reviewed against the governance principles appended to this report.	Review work of R2 and Forum reporting arrangements and risk management against governance principles (Appendix A) and amend and adopt new approaches as required. Further work will be done with the reporting templates to refine areas of common risk across the HSCP to support identification and mitigation of identified risks.	Lead Allied Health Professional / Head of Service, Health and Community Care 30 June 2018	**GREEN** **AMBER**	Review work completed – considered and reflected within review of terms of reference. Work continues to progress the reporting arrangements but not yet complete – revised timescale of end of December 2019	n/a December 2019

Dundee Integration Joint Board Workforce Internal Audit Review *(PAC8-2018)* *27th March 2018*	Work to fully implement the actions in the Workforce and Organisational Development Strategy should continue with regular reporting on progress towards implementation being submitted to the IJB. In addition, Locality Managers should strive towards ensuring that the DH&SCP culture becomes fully embedded. Engaging staff in developing and maintaining the partnership culture as well as sharing and embedding the guiding principles should assist with this.	The DH&SCP management team fully recognises the need to ensure the vision and objectives of the Workforce and Organisational Development Strategy become embedded within the partnership and acknowledged that this is a fundamental element of the partnership's continued development. Implementing in full the actions in the Strategy has been identified by the operational management team as one of the key actions to be delivered over the next 6 months.	Head of Health and Community Care / Head of Finance and Strategic Planning August 2018	**AMBER**	*Review of Workforce and Organisational development strategy as companion document to the review of Strategic Plan. Updated strategy to be presented to the February IJB meeting therefore actions will be taking forward from then.*	~~December 2019~~ March 2020
	Consideration should be given to developing a formal Service Level Agreement (SLA) detailing all key corporate support services to be provided to the DH&SCP by Dundee City Council and NHS Tayside. The service provided should be regularly reviewed along with the SLA to ensure that the defined support is being provided and the SLA continues to be appropriate. Alternatively, in the absence of a SLA, specific details regarding the types and level of support expected should be	The DHSCP Management Team continues to monitor the level of support being provided to the IJB from NHS Tayside and Dundee City Council on an informal basis and responds to the organisations in relation to shortfalls in service provision accordingly. Given the current stage in the partnership's development, with greater knowledge and awareness of what the partnership needs to support its business, the service will progress with its partners, a more formal statement of the	Head of Finance and Strategic Planning August 2018	**RED**	Current level of resources have not enabled progress to be made. Proposals for enhanced IJB support functions being developed within the H&SCP to assist taking this and other governance issues forward.	March 2020

	clearly documented and formally agreed by senior management at the DH&SCP, Dundee City Council and NHS Tayside. In addition, regular reports on the support service requirements should be provided to the IJB.	expected level of support which can subsequently be monitored and report to the IJB.				
	Future workforce plans for DH&SCP should include plans for all areas of delegated responsibility, tailored to deliver the relevant elements of the Strategic Plan. Plans should take account of demand for and availability of staff to maximise the use of resources within the DH&SCP.	As DH&SCP continues to evolve, with the continued development of integrated locality based services and redesign of services, the shape and mix of the workforce required to deliver on the IJB's strategic objectives is becoming clearer and will be reflected in future integrated workforce plans. While acknowledging that further national guidance is awaited on this matter, the first integrated workforce plan will be developed over the next 6 months.	Head of Health and Community Care / Head of Finance and Strategic Planning August 2018	**AMBER**	*Updated Workforce and Organisational Development Plans, compatible with the revised Strategic and Commissioning Plan due to be presented to the IJB in February 2020*	~~December 2019~~ February 2020
Action Plan in Response to the Services for Older People (Edinburgh) Inspection Report *(PAC 29-2018)* *29th May 2018*	Action Plan was requested by the PAC in relation to lessons learned from the Edinburgh inspection and what improvements would be required in Dundee.	A wide range of actions are reflected in this detailed action plan therefore it is not feasible to reflect in this plan – a separate update report will be provided at the May 2019 PAC.	Various with latest timescales for completed action identified as March 2019.	***RED***	*Report to now be presented to the February 2020 PAC meeting*	~~November 2019~~ February 2020
Risk Management Action Plan	Action Plan was required to respond to the findings of the	A wide range of actions are reflected in this detailed	Chief Finance Officer	**AMBER**	*Discussions held between risk*	~~December 2019~~ February 2020

(PAC8-2019) *12th February 2019*	Risk Maturity Assessment presented to the PAC on the 25th September 2018.	action plan therefore it is not feasible to reflect in this plan. A separate update report will be provided to the September 2019 PAC meeting as agreed.	September 2019		*management functions of Dundee City Council and NHS Tayside to agree way forward for actions. Follow up meetings with partners across Tayside scheduled to enable actions to be completed*	
Transformation and Service Redesign Internal Audit Report *(PAC9-2019)* *12th February 2019*	Range of recommendations arising from the report.	Chief Finance Officer to provide an action plan in response to the issues raised within the report to be held on 28th May 2019.	Chief Finance Officer May 2019	***GREEN***	*Action Plan presented on agenda for meeting on 29th May 2019*	*n/a*
2017/18 Annual Internal Audit Report – Action Plan Update *(PAC7-2019)* *12th February 2019*	Review of Action Plan developed to respond to the range of areas for improvement arising from the IJB's 2017/18 Annual Internal Audit Plan.	Wide range of actions detailed in the action plan. Chief Finance Officer to provide an update to the PAC by June 2019 outlining the status of the outstanding actions.	Not Applicable			
The following reflects the detail of this action plan	Clarification of deputising arrangements for the Chief Officer to be presented to the IJB.	Agreement to be reached between Chief Executives of Dundee City Council and NHS Tayside.	Revised February 2019	***RED***	*Discussion to be held between Chief Executives*	~~July 2019~~ November 2019
	Consideration should be given to providing the IJB with reporting on workforce issues including the Workforce and Organisational Development Strategy as well as the partnership forum.	Complete review of Workforce and Organisational Development Strategy and provide update to IJB. Consider frequency and content of update report of activities of Staff Partnership Forum.	Revised April 2019	**AMBER**	*Updated Workforce and Organisational Development Plans, compatible with the revised Strategic and Commissioning Plan due to be presented to the IJB in February 2020.*	~~December 2019~~ February 2020
	Developments in relation to clinical and care governance should take into account the	To be tabled as agenda item for Clinical and Care	Revised March 2019	**GREEN**	Taken into account as part of review of terms of reference.	n/a

	Social Work Scotland guidance document on Governance for quality social care in Scotland.	Governance Group for progressing.				
	Consideration should be given to arrangements required by the IJB to comply with Freedom of Information and Public Records legislation.	Review current arrangements in place across the IJB/NHS Tayside and Dundee City Council to determine if they are effective in meeting the IJB's statutory requirements.	Revised April 2019	**AMBER**	*Self-assessment of arrangements in place deemed to be satisfactory. Further discussion to be arranged with statutory partners to ensure all parties satisfied that requirements being met*	February 2020
	Development of Large Hospital Set Aside arrangements in conjunction with the Scottish Government, NHS Tayside and Angus and Perth and Kinross Integration Joint Boards.	Work progressing with NHS Tayside in association with the 3 Tayside IJB Chief Finance Officers and Scottish Government to conclude the methodology or determining and monitoring the Large Hospital Set Aside to inform commissioning decisions as set out within the legislation.	Revised - March 2019	***RED***	*Value of Large Hospital Set Aside agreed for inclusion in 2018/19 Annual Accounts. Given the need for agreement across Tayside between 3 IJB's and NHS Tayside, timescale revised accordingly – this will ensure the Large Hospital Set Aside is considered as part of the 2020/21 delegated budget process*	~~December 2019~~ March 2020
	Implementation of an action points update to each meeting of the IJB and PAC in addition to an annual work plan to be agreed for both meetings.	To be developed as suggested and implemented with effect from the October 2018 IJB meeting (subsequently revised to April).	Revised April 2019	***GREEN***	*Action plan developed by the Clerk to the Board for each IJB and PAC.*	*n/a*

	Development of improved Hosted Services arrangements around risk and performance management for hosted services.	Current hosted services arrangements subject to discussion across the 3 Tayside Chief Officers and Chief Finance Officers. Proposal to be brought forward to IJB and PAC before the end of the financial year.	Revised June 2019	***AMBER***	*Discussions ongoing with neighbouring IJB's re responsibilities around hosting arrangements.*	~~December 2019~~ March 2020
	Development of an overall Governance Action Plan to progress previous recommended areas for improvement.	To be developed as suggested.	Revised March 2019	**GREEN**	n/a	n/a
	Development of regular IJB and PAC member induction and development process.	To be developed as suggested.	Revised June 2019	**GREEN**	*Development session held prior to October IJB meeting*	n/a
	Further develop the Integration Joint Board's local Code of Governance.	To be developed as suggested.	Revised April 2019	***AMBER***	*Clerk to the Board developing arrangements in conjunction with Chief Finance Officer.*	~~October 2019~~ February 2020
	Present the governance principles adopted by the Health and Social Care Partnership.	To be presented to the February 2019 IJB meeting.	Revised April 2019	***GREEN***	*Report DIJB17-2019 presented to the April IJB noting progress being made and requesting that Dundee City Council and NHS Tayside agree the principles as they apply to Dundee Integration Joint Board. Report to come back to IJB once agreed by both parties*	n/a
	Development of multi-year financial plan as part of the	Development of multi- year financial plan to be part of the budget setting process for	March 2019	***GREEN***	*Incorporated within the review of the Strategic and*	

	review of the Strategic and Commissioning Plan.	2019/20 and beyond which will reflect and be incorporated into the revised Strategic and Commissioning Plan.			*Commissioning Plan. Will also be reflected in the IJB's final budget setting report to be presented to the June 2019 IJB meeting following receipt of confirmation of delegated budget from NHS Tayside.*	
	Update the Integration Joint Board's Participation and Engagement Strategy.	To be taken forward by the Communication and Engagement Group as part of the review of the Strategic and Commissioning Plan.	Revised June 2019	**AMBER**	*Delivering the Strategic Plan is the priority with the Communication and Engagement Strategy a key companion document to the plan – this will be presented to the IJB prior to the end of March 2020*	~~October 2019~~ March 2020
	Develop Scheme of further delegation in relation to delegated services to the Integration Joint Board.	To be developed as suggested.	Revised April 2019	***GREEN***	*Report 16-2019 presented to the April IJB meeting*	*n/a*
	Clarify responsibilities and accountabilities around the impact of General Data Protection Regulations (GDPR) legislation with partner bodies.	Update report to be presented to the October IJB meeting.	October 2018	**GREEN**	n/a	n/a
	Further develop performance report information into a delivery plan framework to ensure IJB fulfils its remit in delivering the direction of travel within the Strategic Commissioning Plan.	To be taken forward by the Strategy and Performance Team, aligned with the review of the Strategic and Commissioning Plan.	Revised July 2019	**AMBER**	Will form part of revised performance monitoring reporting into 2019/20 following approval of revised Strategic and Commissioning Plan.	December 2019

Audit Scotland Annual Audit Report 2018/19	The financial ledger should be fully updated in 2019/20 prior to the approval of the annual accounts.	Ensure the financial ledger is fully updated to reflect all accounting entries prior to the approval of the annual accounts.	Chief Finance Officer June 2020	AMBER	Instruction issued to DCC to ensure this happens at the year end	June 2020
	A long-term financial strategy (5 years or more) supported by clear and detailed financial plans (3 years or more) should be prepared.	Build on the three year financial framework developed during 18/19, which sets out the estimated resources and anticipated increase in expenditure from rising demand and costs of providing services. Continue to work with partner bodies to align longer term financial planning processes and the development of long- term financial strategy on how to close the gap between funding and service provision.	Chief Finance Officer March 2020	AMBER	Work continues to develop the longer term financial framework as part of the budget setting process	March 2020
	The position of the achievement of savings proposals and the impact on the transformation programme should be regularly reported to members	Reports on savings progress and the impact on the transformation programme to be presented regularly to members.	Chief Finance Officer October 2019	GREEN	Financial monitoring report presented from October IJB meeting now includes assessment of progress around savings/transformation	n/a
	The risks arising from EU withdrawal should be included in the IJB's strategic risk register and, as commissioning authority, the IJB should seek to ensure, that satisfactory arrangements have been put in place by	Work with partner bodies to obtain assurance that satisfactory arrangements have been put in place by partner organisations to manage the potential risks arising from EU withdrawal. Reflect the outcome in the strategic risk register	Chief Finance Officer November 2019	AMBER	Information gathered from partner bodies to enable register to be updated	November 2019

	partner bodies to manage potential risks					
	Chair's Assurance Report from the Clinical, Care and Professional Governance Group should be presented to the Performance and Audit Committee on a regular basis	To be included on PAC agendas as appropriate depending on timing of Clinical, Care and Professional Governance group meetings	Clinical Director/Head of Service Health and Community September 2019	**GREEN**	Reports now included on all PAC agendas	n/a
	The IJB should liaise with NHS Tayside and consider the arrangements for regular attendance by a member appointed as the registered medical practitioner providing primary care.	NHS Tayside Board is responsible for appointing the role of registered medical practitioner providing primary care to the IJB. This issue has been noted by the IJB and the Clerk to the Board will formally write to the Chair of NHS Tayside Board on this issue.	Clerk to the Board December 2019	**AMBER**	Clerk has written to NHS Tayside and awaits a formal response	December 2019
	The Governance Action Plan progress report should be further developed to include all improvement action plans	Further develop the Governance Action Plan to include all improvement action plans.	Chief Finance Officer November 2019	**GREEN**	Action Plan now includes both internal and external audit recommendations	n/a
	The IJB should liaise with its partner organisations to ensure an agreed budget is approved prior to the start of the year	An indicative NHS Budget was provided at the IJB budget meeting of 30th March 2019. The final budget from NHS Tayside was consistent with the indicative budget. Continue to work with partner bodies to align budget setting	Chief Finance Officer March 2020	**AMBER**	Continues to be discussed at budget meetings with the parties	March 2020

		processes as far as practicable.				
	Budget monitoring processes should be amended to include: • explanations within monitoring reports to members in relation to changes to the approved budget • monitoring reports on the final out-turn for the year	A final outturn monitoring report for 2018/19 was considered at the June 2019 Board meeting. Budget monitoring reports have not developed to include explanations in relation to changes to the approved budget	Chief Finance Officer March 2020	**GREEN**	Budget monitoring reports from October 2019 now include details of budget changes	n/a
	The IJB should seek to combine financial and performance reporting to ensure that members have clear sight of the impact of variances against budget in terms of service performance.	Continue to explore options on how to combine financial and performance reporting in a format which provide useful information to users.	Chief Finance Officer March 2020	**AMBER**	Progressing as planned	March 2020
	The IJB should review its reserves to ensure they are adequate	Reserves can only be accumulated through year end surpluses of funding. Ensure robust budgeting, monitoring of identified savings and financial monitoring processes in place to identify opportunities to enhance reserves position	Chief Finance Officer March 2020	**AMBER**	Progressing as planned	March 2020
	The IJB should: • review its processes for minute taking. • publish the register of interests covering Board	Further development of the IJB and PAC minutes and papers to ensure full transparency and accurate recording of the discussions,	Chief Officer/ CFO/ Clerk to the Board September 2019	**AMBER**	Minutes expanded as required to reflect key discussions. Further progress to be made	December 2019

	members and senior management on the IJB's website	questions asked and assurances provided				
	Mechanisms and reporting arrangements should be implemented to provide assurance to the Chief Officer and the Board that the IJB has arrangements in place to demonstrate that services are delivering Best Value.	Further learning from other IJB's reporting with regards to Best Value to be gained and considered for reflection in the 2019/20 Annual Performance Report	Chief Finance Officer June 2020	**AMBER**	Progressing as planned	June 2020

ITEM No …8……..

REPORT TO: **PERFORMANCE AND AUDIT COMMITTEE- 26 NOVEMBER 2019**

REPORT ON: **DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT PLAN PROGRESS REPORT**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC43-2019**

1.0 PURPOSE OF REPORT

The purpose of this report is to provide the Performance and Audit Committee with a progress update in relation to the current Internal Audit Plan.

2.0 RECOMMENDATIONS

It is recommended that the Performance and Audit Committee (PAC):

2.1 Notes the progress in delivery of the 2018/19 internal audit plan as well as the anticipated position in relation to the 2019/20 plan as outlined in Appendix 1 to this report.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

4.1 Dundee Integration Joint Board's Internal Audit Plan 2019/20 was approved by the PAC at its meeting of the 24 September 2019 (PAC36-2019 - Item XIV of the minute refers). Work related to completion of the 2018/19 Internal Audit Plan is ongoing and is also included in the progress reported below. Members of the PAC will note that work to progress the substantive audit reviews for 2019/20 has not yet commenced. It is the view of the Chief Finance Officer that the slippage in completion of the 2018/19 internal audit plan and in commencing the 2019/20 plan will not adversely affect the level of assurance the Integration Joint Board will receive at the financial year end in relation to its governance arrangements.

4.2 As per Audit Scotland's recommendation and subsequent agreed action following the Dundee IJB External Audit Annual Report 2016/17, presented to the September 2017 Performance and Audit Committee (PAC21-2017 - Item IV of the minute refers), progress of the Internal Audit Plan is now a standing item on Performance and Audit Committee agendas.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

This report has not been subject to a risk assessment as it a status update and does not require any policy or financial decisions at this time.

7.0 CONSULTATIONS

The Chief Officer, Chief Internal Auditor and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

Date: 15 November 2019

Appendix 1

	2018/19 Internal Audit Plan							
Ref	**Audit**	**Indicative Scope**	**Target Audit Committee**	**Planning Commenced**	**Work in Progress**	**Draft Issued**	**Completed**	**Grade**
D01-19	Audit Planning	Agreeing audit universe and preparation of strategic plan	July 2018	Complete	Complete	Complete	Complete	N/A
D02-19	Audit Management	Liaison with management and attendance at Audit Committee	Ongoing	Complete				
D03-19	Annual Internal Audit Report	CIA's annual assurance statement to the IJB and review of governance self-assessment	July 2018	Complete	Complete	Complete	Complete	N/A
D04-19	Information Governance	Review of IT/ data processes supporting the delivery of the IJB's strategic plan through seamless cross system working	February 2020	Complete	Complete	Complete	No	N/A
D05-19	Finance	Review of arrangements established to control and mitigate Risks 1&2 from the high level risk register	February 2020	Complete	Ongoing	No	No	N/A
D06-19	Governance & Assurance	Governance mapping exercise: Assess the extent to which the IJB's structures support the delivery of strategic objectives Includes review of controls to address Risk 7	February 2020	Complete	Ongoing	No	No	N/A

	2019/20							
Ref	**Audit**	**Indicative Scope**	**Target Audit Committee**	**Planning Commenced**	**Work in Progress**	**Draft Issued**	**Completed**	**Grade**
D01-20	Audit Planning	Preparation of Annual Internal Audit Plan	September 2019	Complete	Complete	Complete	Complete	N/A
D02-20	Audit Management	Liaison with management and attendance at Performance and Audit Committee	N/A	Ongoing				N/A
D03-20	Annual Internal Audit Report	CIA's annual assurance statement to the IJB and review of governance self-assessment	June 2019	Complete	Complete	Complete	Complete	N/A
D04-20	Governance & Assurance	Ongoing support and advice on further development of governance and assurance structures, including issues identified as part of the annual report process and the self assessment against the MSG report and help in implementing an audit follow up process	N/A	Ongoing				N/A
D05-20	Performance management	Adequacy, accuracy, relevance, reliability, data quality, timeliness and interpretation of reporting against the priorities in the Strategic and Commissioning Plan and core integration indicators. Compliance with DL 2016 (05) - Guidance for Health and Social Care Integration Partnership Performance Reports This work will link to Strategic Risk 10 as well as a number of operational risks	March 2020	No	No	No	No	N/A
D06-20	Adverse events management	Implementation of Duty of Candour for Council employees This work will link to Operational risks 30 and 34	March 2020	No	No	No	No	N/A

ITEM No …9……..

REPORT TO: **PERFORMANCE AND AUDIT COMMITTEE – 26 NOVEMBER 2019**

REPORT ON: **QUARTERLY COMPLAINTS PERFORMANCE – 2ND QUARTER 2019/20**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC44-2019**

1.0 PURPOSE OF REPORT

The purpose of this report is to summarise the complaints performance for the Health and Social Care Partnership in the second quarter of 2019/20. The complaints include complaints handled using the Dundee Health and Social Care Partnership Social Work Complaint Handling Procedure, the NHS Complaint Procedure and the Dundee City Integration Joint Board Complaint Handling Procedure.

2.0 RECOMMENDATIONS

It is recommended that the Performance and Audit Committee (PAC):

2.1 Notes the complaints handling performance for health and social work complaints set out within this report;

2.2 Notes the work which has been undertaken to address outstanding complaints within the HSCP;

2.3 Notes the ongoing work taking place to improve complaints handling, monitoring and reporting within the Health and Social Care Partnership.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

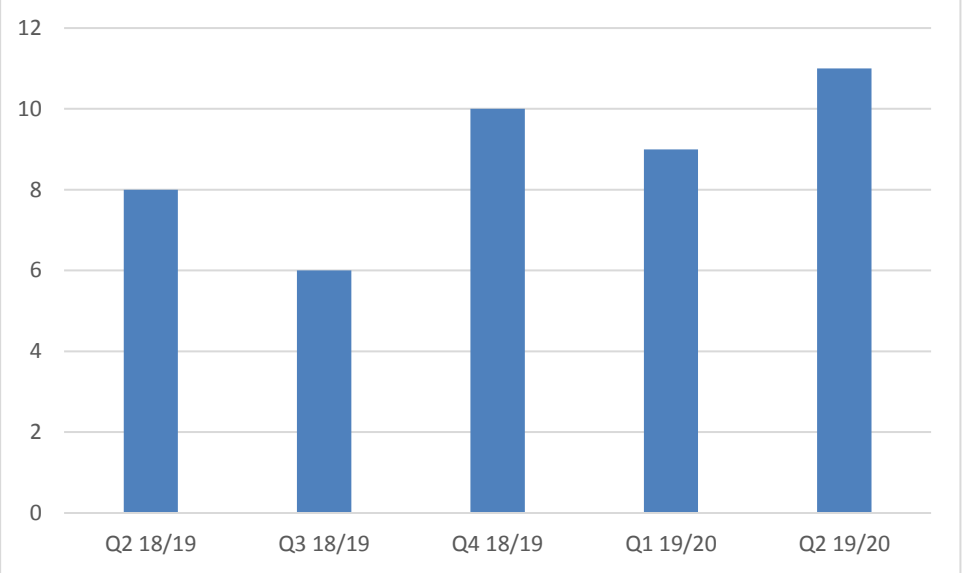
4.1 Since the 1st April 2017 both NHS and social work complaints follow the Scottish Public Service Ombudsman Model Complaint Handling Procedure. Both NHS Tayside Complaint Procedure and the Dundee Health and Social Care Partnerships Social Work Complaint Handling Procedures have been assessed as complying with the model complaint handling procedure by the SPSO.

4.2 Complaints are categorised by 2 stages: Stage 1: Frontline Resolution and Stage 2: Investigation. If a complainant remains dissatisfied with the outcome of a Stage 1: Frontline Resolution complaint, it can be escalated to a Stage 2. Complex complaints are handled as a Stage 2: Investigation complaint. If a complainant remains dissatisfied with the outcome of Stage 2: Investigation complaint they can contact the Scottish Public Services Ombudsman who will investigate the complaint, including professional decisions made. Complaints about the delivery of services are regularly presented to the Clinical, Care and Professional Governance Group to inform service improvement.

4.3 **Social Work Complaints**

In the second quarter of 2019/20 a total of 11 complaints were received about social work or social care services in the Dundee Health and Social Care Partnership. This compares to 9 complaints received in the previous quarter.

Graph 1 - Number of Social Work Complaints received quarterly



The graph shows that there is a relatively small number of complaints received each quarter.

4.4 **Social Work Complaints by Reason for Concern**

Four complaints were received about a delay in responding to enquiries and requests. Three complaints were received about attitude, behaviour or treatment by a member of staff. These complaints were from a variety of services.

Attitude, behaviour or treatment by a member of staff	3
Delay in responding to enquiries and requests	4
Dissatisfaction with our policy	1
Failure to provide a service	2
Failure to follow the proper administrative process	0
Failure to meet our service standards	1

The numbers of social work complaints are relatively small. The complaints received were regarding several services and suggest no themes or patterns of dissatisfaction with services at this time.

4.5 **Social Work Complaints Stages and Outcomes**

Six complaints were handled at a frontline resolution stage. Four of these complaints were partially upheld.

Four complaints were handled as an investigation from the start due to their complexities, one of these complaints was partially upheld.

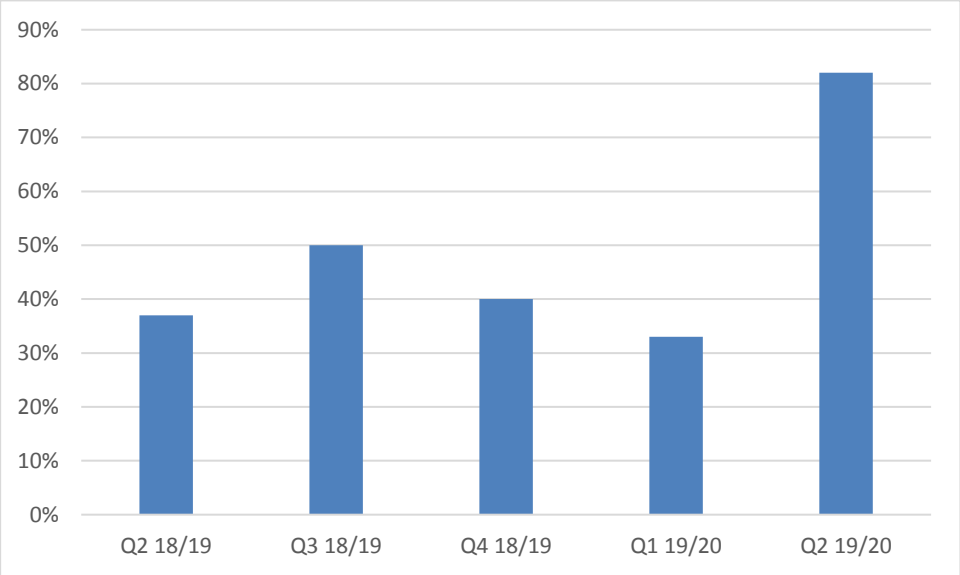
Three complaints were logged with Social Work but were handled jointly and responded to by NHS.

Frontline Resolution		6
Investigation (Escalated from Frontline)		1
Investigation		4
Joint with NHS		3

4.6 **Social Work Complaints Resolved Within Timescales**

Nine of the Social Work complaints received by the Partnership were able to be resolved within the target dates. The other two missed their target date, one was three days late and the other was due to communication issues within the service and the letter not being sent.

Graph 2 - % of Social Work Complaints resolved within timescales



The graph shows that there has been a significant increase in the number of complaints that are resolved within timescales. The Customer Care and Governance Officer is ensuring that delays are kept to a minimum and processes are correctly followed. Meetings with Investigating Officers have begun to reiterate the importance of staying within the timescales and offer support and guidance where required.

4.7 **Planned Service Improvements**

Three out of the five partially upheld complaints have identified a cause and have service improvements planned to address these.

One Planned Service Improvement was around ensuring that staff take care when parking near building works.

Another planned service improvement is to ensure that case recording notes is undertaken with sensitivity.

Lastly, staff have been reminded of the importance of a proper handover of care staff, not only for the staff member but for the Service User.

4.8 **SPSO Complaints**

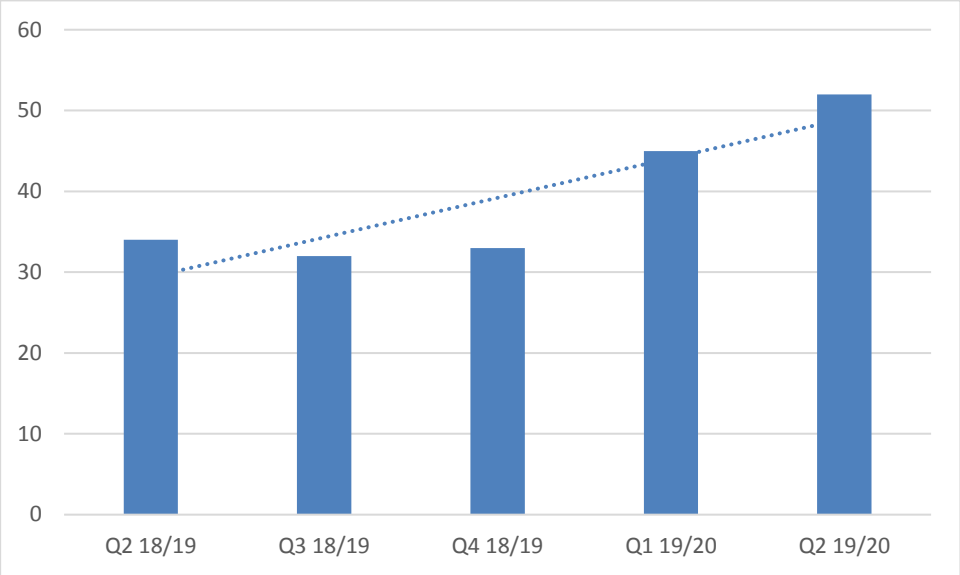
One complaint was referred to the SPSO this quarter and was not taken forward by the SPSO.

4.9 **NHS Complaints**

In the second quarter of 2019/20 a total of 52 complaints were received about Dundee Health and Social Care Partnership health services. These are complaints which have been coded against DHSCP, there may be other complaints where DHSCP have contributed to a joint response:

This compares to 45 complaints received in the first quarter in 2019-20 and represents a 15% increase in complaints received.

Graph 3 – Number of NHS Complaints received



The graph shows that there has been a gradual increase in the number of complaints received over the past year.

4.10 **NHS Complaints by Theme**

The top three themes were Clinical Treatment; Attitude and Behaviour; and Communication (Oral).

The top three sub themes were Staff attitude; Lack of Support; and Disagreement with treatment/care plan.

4.11 **NHS Complaints Stages**

Eleven complaints were handled at a frontline resolution stage. Seven of these complaints were upheld, and three were partially upheld.

Fourteen complaints were handled as Stage 2 Escalated complaints. Four were fully upheld and 5 were partially upheld.

Twenty five complaints were handled as a Stage 2 complaints from the start. Seven were fully upheld and ten were partially upheld.

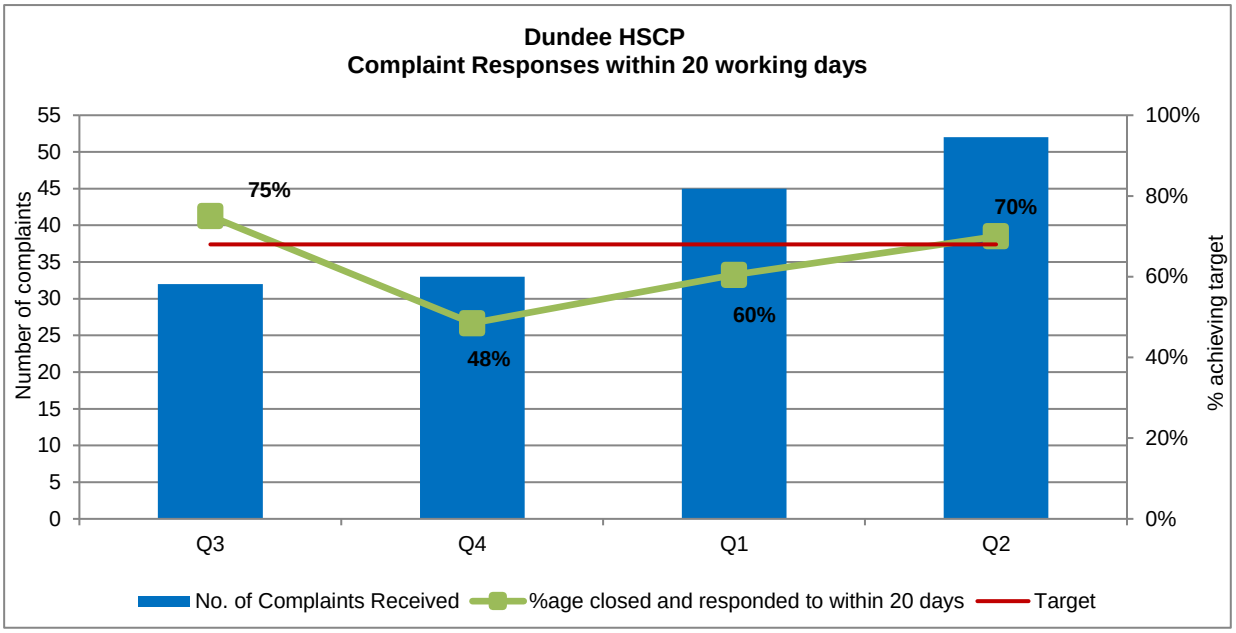
90% of Frontline resolution complaints were either upheld or partially upheld. In contrast 63% of stage 2 complaints were upheld or partially upheld.

Frontline Resolution	11
Investigation (Escalated from Frontline)	14
Investigation	27

4.12 **Closed NHS Complaints Resolved within Timescales**

40 complaints were closed within the second quarter, and 70% (28) were closed within timescales.

Graph 4 - % of closed NHS complaints closed within timescales

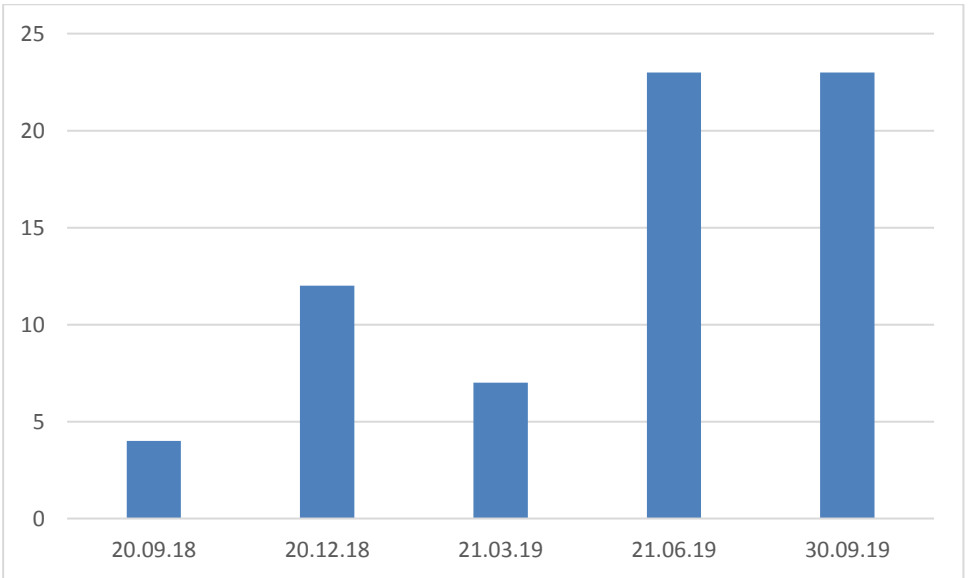


The graph shows that there has been an increase in the number of closed complaints resolved within their target date across the last three quarters. While the volume of complaints being received has increased each quarter, the majority of these are being responded to quickly.

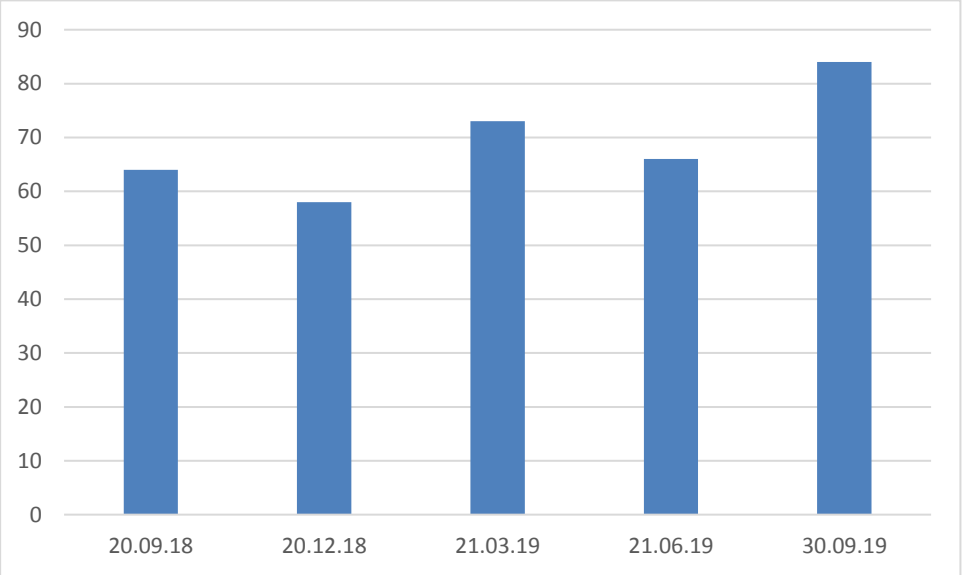
4.13 Outstanding NHS Complaints

The graph below shows that there has been a significant increase in the amount of NHS complaints that are overdue in the past year and this has remained for the second quarter in a row.

Graph 5 - Snapshot of number of open overdue NHS complaints at a given date



Graph 6 - Snapshot of average length in working days of overdue NHS complaints at a given date



The above graph shows that the average length of overdue complaints has remained relatively static over the past year. However work has been ongoing to complete the backlog of overdue complaints and it is anticipated that the average length will reduce in the next quarter.

In the second quarter 59 complaints were closed and the average time taken to close those complaints was 67 days.

A number of discussions have taken place with NHS Tayside to identify how we can improve our complaint response times. A patient feedback workshop is planned as part of Clinical and Care Governance work.

However, it has become clear that one of the main factors leading to long response times (in some service areas) is our approach to formal complaint responses. In particular some Complaint Investigation Officers believe that a patient centred response requires the complaint issues not only to be investigated, but for a solution to be put in place, before we formally respond to the patient. Whilst this approach often provides a more meaningful response, this can lead to very long response times. It has been suggested that we need to review our approach and should be formally responding to the complainant at an earlier stage. Work will be undertaken with Investigation Officers to support them to provide complaint responses timeously whilst retaining the quality of the outcome response.

5.0 IJB Complaints

No complaints about the Integration Joint Board have been received.

6.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

7.0 RISK ASSESSMENT

This report has not been subject to a risk assessment as it is provided for information and does not require a policy decisions from the PAC.

8.0 CONSULTATIONS

The Chief Finance Officer and the Clerk were consulted in the preparation of this report.

9.0 BACKGROUND PAPERS

None

Dave Berry
Chief Finance Officer

DATE: 15 November 2019

ITEM No …11……..

PERFORMANCE AND AUDIT COMMITTEE – ATTENDANCES - JANUARY 2019 TO DECEMBER 2019

COMMITTEE MEMBERS - (* - DENOTES VOTING MEMBER – APPOINTED FROM INTEGRATION JOINT BOARD)

Organisation	Member	12/2	25/3	28/5	24/9	26/11
Dundee City Council (Elected Member)	Ken Lynn *	A	✓	✓	✓	
Dundee City Council (Elected Member)	Helen Wright *	✓	✓	✓	✓	
NHS Tayside (Non Executive Member)	Jenny Alexander*	✓	A	✓	A	
NHS Tayside (Non Executive Member)	Norman Pratt *	✓	A			
NHS Tayside (Non Executive Member)	Nic Beech *			A	✓	
Chief Officer	David W Lynch	✓	✓	✓	A	
Chief Finance Officer	Dave Berry	✓	✓	✓	✓	
NHS Tayside (Registered Medical Practitioner (not providing primary medical services)	Cesar Rodriguez	A	A			
NHS Tayside (Registered Medical Practitioner – not providing primary medical services)	James Cotton			A	A	
Dundee City Council (Chief Social Work Officer)	Jane Martin	✓	✓	✓		
Dundee City Council (Chief Social Work Officer)	Diane McCulloch				✓	
NHS Tayside (Staff Partnership Representative)	Raymond Marshall	A	A	✓	A	
Carers' Representative	Martyn Sloan			✓	✓	
Chief Internal Auditor ***	Tony Gaskin	A	✓	A	✓	
Audit Scotland ****	Bruce Crosbie	****	****	****	✓	

✓ Attended

A Submitted apologies

A/S Submitted apologies and was substituted

☐ No longer a member and has been replaced / was not a member at the time

* Denotes Voting Members

** Denotes Office Bearer. Periods of appointment are on fixed terms in accordance with legislation. At meeting of the Integration Joint Board held on 30th October, 2018, Ken Lynn was appointed as Chair (the Chair of the Committee cannot also be the Chair of the Integration Joint Board).

*** The Chief Internal Auditor is a member of the Committee and is not a member of the Integration Joint Board.

**** Audit Scotland are not formal members of the Committee and are invited to attend at least one meeting of the Committee a year.

(Note: First meeting of the Committee was held on 17th January, 2017).

(Note: Membership are all members of the Integration Joint Board (only exceptions are Chief Internal Auditor and Audit Scotland).