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The Public Bodies (Joint Working) (Scotland) Act 2014 is the legislative framework for the integration of health and social care services in Scotland. This briefing describes how the legislation is being implemented and examines key issues for the integration agenda.
CONTENTS

EXECUTIVE SUMMARY ........................................................................................................... 3

INTRODUCTION .......................................................................................................................... 4

THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014 ........................................... 4

INTEGRATION AUTHORITIES .................................................................................................... 5

INTEGRATED SERVICES .............................................................................................................. 5
INTEGRATION SCHEMES ............................................................................................................ 5
ESTABLISHMENT OF INTEGRATION AUTHORITIES .............................................................. 6
STRUCTURE ............................................................................................................................... 6

Integrated Joint Board (Body Corporate) Model ....................................................................... 6
CASE STUDY: Cùram Is Slàinte Nan Eilean Siar (Western Isles Health and Social Care Partnership) .................................................................................................................. 8
Lead Agency Model ................................................................................................................... 9

STRATEGIC COMMISSIONING PLANS ..................................................................................... 9

CASE STUDY: Edinburgh Health and Social Care Partnership.................................................... 10

LOCALITIES .............................................................................................................................. 11

FINANCE .................................................................................................................................. 11

OUTCOMES .............................................................................................................................. 13

MEASURING PERFORMANCE .................................................................................................. 14

ISSUES ....................................................................................................................................... 15

BUILDING RELATIONSHIPS .................................................................................................... 15
STRATEGIC PLANS ................................................................................................................... 16
SETTING BUDGETS ................................................................................................................... 16
Set aside budgets ....................................................................................................................... 16
DELIVERING SAVINGS .............................................................................................................. 16
ROLE OF LOCALITIES .............................................................................................................. 17
WORKFORCE PLANNING ......................................................................................................... 17
General Practitioners ................................................................................................................ 17
REPORTING PERFORMANCE .................................................................................................... 18
SHARING GOOD PRACTICE ..................................................................................................... 18
COMPLAINTS .............................................................................................................................. 18

NEXT STEPS ............................................................................................................................. 18

THE HEALTH AND SPORT COMMITTEE ............................................................................... 18

ANNEX A: ESTIMATED EXPENDITURE ON DELEGATED FUNCTIONS, 2014-15 ......................... 19

ANNEX B: INTEGRATION INDICATORS: .................................................................................... 20

SOURCES .................................................................................................................................. 21

RELATED BRIEFINGS ................................................................................................................ 24
EXECUTIVE SUMMARY

The Public Bodies (Joint Working) Act 2014 sets out the legislative framework for integrating health and social care. It creates a number of new public organisations, known as integration authorities and aims to break down the barriers to joint working between NHS boards and local authorities.

The integration of health and social care was predicted to result in potential budget efficiencies of between £138 and £157 million as a result of reducing delayed discharges, unplanned admissions to hospital, variations between areas and inefficiencies. The Scottish Government has estimated that the initial cost of integrating adult services will be £34.2 million over the five years up to 2016/17 and £6.3 million after this.

NHS boards and local authorities were required to jointly submit an integration scheme for each area setting out which functions will be delegated to the integration authority. Thirty one integration authorities were established – the majority of these followed the integrated joint board model with only the Highland Partnership following the lead agency model.

The Act requires the integration of the governance, planning and resourcing of adult social care services, adult primary care and community health services and some hospital services. Other areas such as children’s health and social care services, and criminal justice social work can also be integrated.

Each integration authority is required to develop a strategic commissioning plan outlining how services will be planned and delivered using integrated budgets and an annual financial statement.

Each integration authority is also required to produce an annual performance report. The first performance reports (for 2016-17) must be published by the end of July 2017.

A number of factors influence the success of the integration of health and social care, such as building relationships across different sectors and understanding how local arrangements will work in practice.

Discussions around the progress of integration have focused on the development of strategic plans, setting budgets, the role of localities and the involvement of GPs, workforce planning, performance reporting and sharing good practice.

In her priorities speech in May 2016, the First Minister, Nicola Sturgeon MSP, said that the “integration of health and social care … is the most radical reform in healthcare in Scotland since the foundation of the NHS” (Scottish Parliament, 2016).
INTRODUCTION

In Scotland, as in many developed countries, there has been an increased focus on the integration of health and social care services since the 1970s (Woods, 2001). A key driver towards integration has been the projected increase in demand for health and social care as a result of an increasingly ageing population. Audit Scotland’s report Changing models of health and social care (2016) highlights the increasing pressures that health and social care services are facing as a result of demographic changes, with a considerable increase in the percentage of the population who will be aged 75 and older. Older people make more use of hospital services than the rest of the population. An aim of the integration agenda is to help reduce unnecessary admissions to hospital and delayed discharges (Audit Scotland, 2016). Integration is seen as a way to make more efficient and effective use of limited resources (Suter, Oelke, Adair and Armitage, 2009) and is believed to be central to the challenge of improving outcomes for patients and service users (Curry and Ham, 2010 as cited in Thustlethwaite, 2011).

A number of policy initiatives in Scotland have sought to encourage greater integration of health and social care services. These have included the Joint Futures Group (1999), the Community Care and Health (Scotland) Act 2002, Community Health Partnerships (CHPs) (2004), Integrated Resource Framework (2008) and the Commission on the Future Delivery of Public Services (the Christie Commission) (2011). However, despite such initiatives there remained concerns that joint working was not as effective as it could be (Robson, 2013).

A discussion of the history of integrated care in Scotland and the evidence for integration can be found in SPICe briefings 12/48 Integration of Health and Social Care: International Comparisons and 13/15 Public Bodies (Joint Working) (Scotland) Bill.

THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

On 12 December 2011, the Cabinet Secretary for Health Wellbeing and Cities Strategy announced the Scottish Government’s plan to integrate adult health and social care. The Public Bodies (Joint Working) (Scotland) Bill was introduced in the Scottish Parliament on 28 May 2013. The Bill set out the legislative framework for integrating health and social care.

The policy ambition of the Bill was to:

“...improve the quality and consistency of services for patients, carers, service users and their families; to provide seamless, joined up quality health and social care services in order to care for people in their homes or a homely setting where it is safe to do so; and to ensure resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older.” (Scottish Parliament, 2013, p 1).

The Public Bodies (Joint Working) Act 2014 (the Act) created a number of new public organisations, known as integration authorities, with a view to breaking down barriers to joint working between NHS boards and local authorities (Audit Scotland, 2015). It placed a requirement on NHS boards and local authorities to integrate health and social care budgets. It put in place nationally agreed outcomes and a requirement on partnerships to strengthen the role of clinicians and care professionals, along with the third and independent sectors, in the planning and delivery of services (Scottish Government, 2016a).

The Regulations and Orders supporting the Act are available on the Scottish Government’s website.
Community Health Partnerships ceased to exist when their functions were fully taken over by integration authorities.  

INTEGRATION AUTHORITIES  

INTEGRATED SERVICES  

The 2014 Act required NHS boards and local authorities to integrate the governance, planning and resourcing of adult social care services, adult primary care and community health services and some hospital services.  

The hospital services to be integrated included accident and emergency services, general medicine, geriatric medicine, rehabilitation medicine, respiratory medicine, psychiatry of learning disability, palliative care, addiction and substance dependency services and mental health services provided by GPs in hospital.  

The Act also allowed NHS boards and local authorities to integrate other areas such as children’s health and social care services and criminal justice social work (Audit Scotland, 2015). All integration authorities are delegating some aspect of their children’s health services.  

The functions that must be delegated are set out in the following regulations: The Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014 and The Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Regulations 2014.  

Integration authorities (also known as partnerships) are jointly accountable to Scottish Ministers, local authorities, NHS board chairs and the public for delivering the nationally agreed outcomes (Scottish Government, 2016b).  

INTEGRATION SCHEMES  

The 2014 Act requires NHS boards and local authorities to jointly submit an integration scheme for each area setting out the detail of which functions will be delegated to the integration authority. These schemes are intended to achieve the National Health and Wellbeing Outcomes and had to be approved by Scottish Ministers.  

An integration scheme sets out the key agreements that need to be reached in developing integrated arrangements and include information such as:  

- The model of integration chosen  
- The scope of functions and services that are to be delegated  
- The clinical and care governance arrangements  
- Financial management  
- Operational arrangements  
- And a number of other key agreements  

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1. Once integration schemes were approved, integration authorities could take on delegated responsibility for budgets and services at any time between 01 January 2015 and 1 April 2016 (Audit Scotland, 2015).  
2. The Scottish Government published Health and Social Care Functions Supporting Note which describes which health and social care functions must and may be integrated under the legislation.
The integration schemes can be accessed from the Scottish Government’s website. The integration schemes were required to be in place by 1 April 2015 and fully implemented by 1 April 2016.

ESTABLISHMENT OF INTEGRATION AUTHORITIES

The Act allowed for partners to work jointly. Two or more local authorities can work with a NHS board to create an integration authority. For example, Clackmannanshire and Stirling local authorities created a partnership with NHS Forth Valley to form Clackmannanshire and Stirling Integration Joint Board. Thirty one integration authorities have been established across Scotland. Figure 1 shows integration authorities by NHS board.

STRUCTURE

The Act set out a framework for creating the integration authorities. It allowed NHS boards and local authorities to integrate health and social care services in two ways, the integrated joint board model or the lead agency model.

Integrated Joint Board (Body Corporate) Model

Under this model an Integration Joint Board (IJB) is set up and the NHS board and local authorities delegate the responsibility for planning and resourcing service provision for delegated adult health and social care services to the IJB. NHS boards and local authorities delegate budgets to the IJB which then decides how to use the resources.

The number of representatives on the IJB from the local authority and NHS board is specified in the integration scheme. They must nominate at least three members each, but may nominate more as long as the same number is nominated by each group. Local authorities will nominate councillors and the NHS board will nominate non-executive directors (or other members of the health board if necessary).

The IJB must also include a carer representative, a GP representative, a nurse representative, a secondary medical care practitioner, a service user representative, a staff-side representative, a third sector representative, an officer who is responsible for financial administration (Section 95 Officer), the Chief Officer and the Chief Social Worker (Scottish Government, 2015b).

Board members of IJBs are a mix of voting and non-voting members. Councils and NHS boards are each required to nominate at least three voting members. The NHS board and council can nominate more members, but both partners need to agree to this and the number from each body needs to be equal. The IJB should also include non-voting members, including a service user and a representative from the voluntary sector.

Audit Scotland (2015) highlighted that IJBs include representatives from a wide range of organisations and that this approach has benefits but that there is also the risk that large boards will find it difficult to make decisions. There is also some uncertainty about the role of non-voting members, such as representatives from the voluntary sector and carers (Audit Scotland, 2016a).

Under this model, staff that deliver services are not required to transfer from one employer to another or change their employment terms and conditions (Scottish Government, 2015c).

In the first instance, IJBs are not expected to directly employ staff. IJBs can appoint sub-committees to carry out any of their functions to support the effective working of the IJB (Scottish Government, 2015b).
Figure 1: Health and Social Care Integration Partnerships by NHS Board

CASE STUDY: Cùram Is Slàinte Nan Eilean Siar (Western Isles Health and Social Care Partnership)

The Western Isles IJB comprises: Comhairle Nan Eilean Siar representatives and NHS Western Isles representatives amongst others.

- NHS Western Isles Chair
- NHS Non-Executive Director
- NHS Non-Executive Director
- NHS Non-Executive Director
- Council Leader
- Council Convenor
- Elected Member
- Elected Member
- Chief Social Work Officer
- Lead Nurse
- GP
- Secondary Care
- Chief Finance Officer
- Western Isles Community Care Forum
- Western Isles Carers, Users and Supporters Network
- Trades Union Representative
- Trades Union Representative
- C-CIG (Co-Cheangal Innse Gall) (third sector interface)
- Service user representative
- Chief Officer

Figure 2: Organisational chart for a typical IJB

Source: Health and Social Care Integration, Audit Scotland, 2015, licensed under the Open Government Licence.
**Lead Agency Model**

Under this model, the NHS board or local authority takes the lead in planning and delivering integrated service provision in their area. Information on which body will be the lead agency is set out in the integration scheme. The Chief Executive of the lead agency has the responsibility to develop the strategic plan for the integrated services and set up the strategic planning group.

The NHS board and local authority are also required to establish a joint monitoring committee to scrutinise the delivery of integrated arrangements and report on progress.

The lead agency model requires staff to transfer to either the council or the NHS board (Audit Scotland, 2016a).

Only one integration authority has used the lead agency model. NHS Highland and Highland Council has formed the [Highland Partnership](#). The [Highland Partnership integration scheme](#) sets out which functions are to be delegated. Highland Council is the lead agency for children’s community health and social care services and NHS Highland is the lead agency for adult health and care services.

**STRATEGIC COMMISSIONING PLANS**

Each integration authority has to establish a strategic planning group to support the strategic planning process. The strategic planning group is involved in the development and review of the strategic commissioning plan (also known as the strategic plan), which must be reviewed, at least, every three years (Scottish Government, 2015b).

The Act places a duty on integration authorities to develop a strategic commissioning plan for integrated functions and budgets. The strategic commissioning plan sets out how services will be planned and delivered using the integrated budgets. Stakeholders are to be fully engaged in the preparation, publication and review of strategic commissioning plans (Scottish Government, 2014).

Strategic planning groups are required to involve:

- Users of health and social care
- Carers of health and social care users
- Commercial and non-commercial providers of healthcare
- Health and social care professionals
- Non-commercial providers of social housing
- Third sector bodies

The strategic commissioning plan must include information on the financial resources that are available including the allocated budget and how this is to be used (Scottish Government, 2016b).

The strategic plans include information on the health and social care services that will fall within the management remit of the integration authority. This varies by integration authority, but Edinburgh Health and Social Care partnership has been used to illustrate some of the services that can fall under the responsibility of the authority.

All of the strategic plans were published by 1 April 2016, but will continue to be developed and updated.
CASE STUDY: Edinburgh Health and Social Care Partnership

**Adult Social Care Services**
- Assessment and care management including occupational therapy
- Residential care
- Extra care housing and sheltered housing (housing support provided)
- Intermediate care
- Supported housing- learning disability
- Rehabilitation- mental health
- Day services
- Local area co-ordination
- Care at home services
- Reablement
- Rapid response
- Telecare

**Community Health Services**
- District nursing
- Services relating to an addiction or dependence on any substance
- Services provided by allied health professionals
- Public dental service
- Primary medical services (GP)*
- General dental services*
- Ophthalmic services*
- Pharmaceutical services*
- Out-of-hours primary medical services
- Community geriatric medicine
- Palliative care
- Mental health services
- Continence services
- Kidney dialysis
- Prison health care service
- Services to promote public health
*Includes responsibility for those aged under 18

**Hospital Based Services**
- A&E
- General medicine
- Geriatric medicine
- Rehabilitation medicine
- Respiratory medicine
- Psychiatry of learning disability
- Palliative care
- Hospital services provided by GPs
- Mental health services provided in a hospital - with exception of forensic mental health services
- Services relating to an addiction or dependence on any substance
LOCALITIES

The Act requires each integration authority to establish at least two localities. This aims to provide an organisational mechanism for local leadership of service planning, to be fed upwards into the integration authority’s strategic commissioning plan. Localities are intended to have real influence on how resources are spent in their area.

Localities bring together local GPs and other health and care professionals, representatives of the housing sector, representatives of the third and independent sectors, carers’ and patients’ representatives and people managing services (Scottish Government, 2015d). A representative from each locality is expected to be part of the strategic planning group (Audit Scotland, 2015).

There is wide variation in the number and size of localities in various areas. For example, Edinburgh Integration Joint Board has four localities (with an average population of 120,000). In contrast, Shetland Integration Joint Board has seven localities (with an average population of 4000) (Edinburgh Health and Social Care Partnership, 2015 and Audit Scotland, 2015).

Integration authorities are required to publish annual performance reports which include a description of the arrangements made in relation to consulting and involving localities, an assessment of how these arrangements have contributed to the provision of services and the proportion of the total budget that was spent in relation to each locality (Scottish Government, 2016d).

FINANCE

In the Financial Memorandum to the Public Bodies (Joint Working) Scotland Bill, the Scottish Government predicted that the integration of health and social care could result in budget efficiencies of between £138 and £157 million. These potential efficiencies could result from reducing delayed discharges, reducing unplanned admissions to hospital and reducing variations between areas. The Scottish Government has estimated that the initial cost of integration adult services will be £34.2 million over the five years up to 2016/17 and £6.3 million after this (Audit Scotland, 2015).

Integration authorities must publish an annual financial statement which sets out the total resources included in the plan for that year (Scottish Government, 2015b). As of August 2016, the budgets for 2016-17 have yet to be finalised but are expected to total over £9 billion (Scottish Government, 2016c). Although the IJBs do not hold the money, which comes from NHS boards and local authorities, they have the (delegated) power to direct how it is spent.

Regulations define the minimum scope of services to be delegated to integration authorities. In response to the Health and Sport Committee’s report on NHS Boards Budget Scrutiny 2015-16 Paul Gray, Director-General Health & Social Care and Chief Executive NHSScotland, commented that “the minimum scope of the budget is covered by legislation, and will include at least adult social care, adult community health care and those aspects of adult hospital care that offer the best opportunities for service redesign in support of prevention and better outcomes” (Scottish Government, 2015g).

On the basis of the minimum scope, the Scottish Government estimated that £8.2 billion would be spent on delegated functions in 2014-15 (the first ‘shadow’ year for integrated joint boards). Of the total £13.1 billion expenditure on health and social care in Scotland in 2014-15, 62% was expected to be delegated on the basis of the minimum scope of services. This includes 60% of the NHS board budgets and 72% of the social work budget. Within these totals, around 34% of all hospital services expenditure will be delegated (primarily unplanned hospital care), the majority (84%) of community health services will be delegated, all family health services, older
persons’ services and adult social work expenditure will be delegated. For more information see Annex A: Estimated expenditure on delegated functions, 2014-15.

In reality, the total value of delegated functions will be higher than this, as integration authorities have decided to delegate a wider range of functions than set out in the regulations. For example, all integration authorities have delegated some of their children’s health services.

In its report on the Draft Budget 2015-16, the Session 4 Health and Sport Committee noted that:

“…there was a wide variation in the percentage allocated by boards to IJBs and in the mix and range of services that boards had delegated to IJBs. In NHS Orkney and NHS Shetland, planned resources had been split almost equally from the health board and the local authority, while in all other areas, the NHS board had allocated a larger sum than the local authority to the IJB. For example, in Dumfries and Galloway, the health board accounted for the largest share (81%) of the total planned budget for IJBs” (Scottish Parliament Health and Sport Committee, 2015, col 108-110).

Shadow budgets for 2015-16 have been determined on the basis of existing budgets for those services that are to be delegated. However, in future years, an annual budget setting process will need to be developed to determine the allocation of resources (Hudson, 2016).

The Scottish Government has published financial guidance to assist health boards and local authorities prepare for integration.
OUTCOMES

The National Health and Wellbeing Outcomes are set out in regulations under section 5(1) of the Act and apply across all integrated health and social care services. They are intended to provide a strategic framework for the planning and delivery of health and social care services (Scottish Government, 2015e). When developing strategic commissioning plans, the integration authorities must have regard to the national health and wellbeing outcomes.

In addition, 23 integration indicators (Annex B) have been developed in partnership with NHS Scotland, COSLA and the third and independent sectors, drawing together measures that are appropriate for the whole system under integration. These indicators are intended to support the outcomes.

The Scottish Government’s guidance on performance reporting notes that the Information Service Division (ISD) of NHS National Services Scotland will publish the core integration indicators in a way which will allow national benchmarking. The core integration indicators are intended to provide an indication of progress towards the outcomes that can be compared across integration authorities and described at Scotland level and over the longer term (Scottish Government, 2016d).

The Scottish Government has indicated that these indicators are being revisited to focus more on primary care, secondary care and children’s health and social care (Scottish Government, 2016b).
MEASURING PERFORMANCE

The Act places a duty on integration authorities to publish an annual performance report in relation to the National Health and Wellbeing Outcomes as set out in the Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014 (Scottish Government, 2015b). The intention is that these performance reports will include financial information on how resources have been allocated to specific outcomes (Hudson, 2015).

The Scottish Government has published guidance for integration authorities on publishing annual performance reports (Scottish Government, 2016d). This notes that performance reports must be published no later than four months after the end of that reporting year. Reporting years begin on 1 April annually. Therefore, reports covering the period April 2016 to March 2017 must be published by the end of July 2017.

The guidance notes that the performance reports must be assessed in the context of the strategic commissioning plan and financial statement, and focus on how the expenditure has achieved, or contributed to achieving, the health and wellbeing outcomes. Performance reports must also include information on financial performance, for the reporting year and by comparison with the 5 preceding years (or with all previous reporting years if this is less than 5 years). The report must also assess whether the best value has been achieved in terms of the planning and delivery of services, and include details of any inspections carried out relating to the functions delegated to the integration authority (Scottish Government, 2016d).

ISD is continuing to develop an extensive database of linked data on health and social care activity, costs and demographic information to support analysis and monitoring of integrated services. This information is being made available to NHS boards, local authorities and integration authorities to help them gain a better understanding of the needs of their local population, current patterns of care and how resources are being used.

“Source” (previously known as the Health and Social Care Data Integration and Intelligence Project) is a long-term project that is developing routine health and social care data collection which can cost social care activity and be linked with routinely collected health data (such as acute, mental health and geriatric long stay hospital admissions, accident and emergency attendances, hospital outpatient appointments community prescribing and community health) and National Record of Scotland data on deaths (ISD Scotland).

ISD is also providing data and analytical support through a local intelligence support team initiative (Audit Scotland, 2015, Scottish Government, 2016c).
ISSUES

There has been a great deal of research on the key factors which influence the success, or otherwise, of the integration of health and social care systems. A number of common themes are apparent when reviewing the literature. Influencing factors tend to fall into a number of categories: organisational issues; financial issues; factors related to people and relationships; and policy issues (Burgess, 2012). Audit Scotland (2015) identified a number of issues in its audit of health and social care integration, the majority of which focused on how integration will work in practice. The Health and Sport Committee has also considered the issues surrounding the integration of health and social care during its consideration of the Public Bodies (Joint Working) (Scotland) Bill, Scottish Government Draft Budget 2016-17 and NHS Board Budgets.

BUILDING RELATIONSHIPS

In terms of enablers for integration, factors that have been highlighted in the literature include a shared vision across sectors, time building relationships, existing relationships, history of previous joint working, professionals involved in developing services, communication and readiness to change (Burgess, 2012).

Audit Scotland’s report (2015) notes that NHS boards, local authorities and integration authorities need to be clear about how local arrangements will work in practice. Highlighting:

- Good governance needs to be quickly established.
- Members of the integration authority need to understand and respect differences in organisational culture and backgrounds. There are differences in how local authorities and NHS boards operate. Local authorities are accountable to the local electorate while NHS boards report to Scottish Ministers. There are also differences in how local authorities and NHS boards work with the private sector.
- Integration authority members will have to manage conflicts of interest. Typically, IJB voting members are also councillors or NHS board members.
- Only a few integration authorities will oversee the operation of acute services in their areas. Dumfries and Galloway IJB will oversee all acute hospital services as there is essentially one acute hospital in the area but it may be harder for a small integration authority such as Midlothian to influence a large tertiary centre such as the Royal Infirmary of Edinburgh (Audit Scotland, 2016a).
- A clear understanding is needed of who is accountable for service delivery. There is a risk that the complex relationships between integration authorities, local authorities and NHS boards might distort the clear understanding of who is accountable and that this could be put to the test when there is service failure.
- Integration authorities need to establish effective scrutiny arrangements.

The Scottish Government has established support networks for IJB chairs and finance officers such as learning events and support from the Joint Improvement Team (Audit Scotland, 2015). The Scottish Government has also created a Chief Officers Network. This network meets regularly to exchange information and to discuss common challenges as integration arrangements progress.
STRATEGIC PLANS

Audit Scotland (2015) commented that many of the strategic plans being developed are “aspirational and lack important detail”. This, in part, has been attributed to difficulties in agreeing budgets and has put into question the “readiness of IAs to make an immediate impact in reshaping local services” (p31). Audit Scotland noted that strategic plans can be quite general and do not provide detail on what money and staff are available to match the priorities that have been identified. They were also found not to provide detail on what level of acute service is needed in an area and how resources will be moved towards preventative and community based care. The strategic plans were also found not to include performance measures that directly relate to national outcomes.

SETTING BUDGETS

Audit Scotland (2015) noted that there are “significant concerns about funding” (p.30). A number of NHS boards and local authorities have had difficulties in agreeing budgets for the integrated authorities. Despite the integration authorities being operational by April 2016, some IJB’s 2016/17 budgets were not available as of August 2016 (Scottish Government, 2016c).

Audit Scotland (2015) highlighted the potential risk that integration authorities may face a disproportionate reduction in their budgets if local authorities and NHS boards seek to protect services that are fully under their control. Also, local authorities have different financial planning cycles with local authority budgets being agreed in December and NHS budgets being agreed in March. A key issue is that integration authorities lack any real certainty about medium to long term budgets (Audit Scotland, 2016a).

Set aside budgets

The set aside budget is the amount set aside by the NHS Board for commissioned services in large hospitals. Information on how the set aside budget should be calculated can be found in the Scottish Government’s Finance Guidance. In its report, Audit Scotland (2015) noted that

“…there are difficulties in agreeing these set-aside budgets, despite the Scottish Government issuing specific guidance. The current difficulties relate to how to determine the integrated and non-integrated costs for these hospitals and how to allocate a fair share to each IJB within the NHS board area. More fundamentally, however, there is a risk that NHS boards may regard this funding as continuing to be under their control, making it difficult for IAs to use the money to shift from acute hospital care to community-based and preventative services.”(p.30-31).

DELIVERING SAVINGS

Questions have been raised about the ability of the integration of health and social care to deliver the potential efficiencies of between £138 and £157 million as set out in the Financial Memorandum for the Public Bodies (Joint Working) (Scotland) Act 2014. There is also uncertainty whether these anticipated potential efficiencies will result in more money being available for community based and preventative care investments (Audit Scotland, 2015).

The Session 4 Health and Sport Committee noted in its report on the Draft Budget 2015-16, that there was a risk “that the acute sector was not going to be sufficiently challenged to reconfigure the way it organises and provides its services, with the result that the hoped for degree of integration and reorganisation of services may not be fully realised”(Scottish Parliament Health and Sport Committee, 2015, para 106).
ROLE OF LOCALITIES

Localities have been identified as being key to the success of integration. Audit Scotland (2015) noted that the arrangements of localities were relatively undeveloped. Although GPs were involved in locality planning, concerns were raised about their ability to remain involved and there was some scepticism following earlier attempts to shift to community based services.

WORKFORCE PLANNING

Currently, integration authorities are responsible for commissioning services but do not directly employ staff. Audit Scotland (2015) identified a need for workforce planning to show how an integrated workforce will be developed. It notes that few integration authorities have developed a long-term workforce strategy and that there will be implications for the skills and experience staff will need to deliver community-based services. Workforce planning for integration authorities will need to take a broad view to include carers and voluntary workers and the groups will need to be included in plans for resources, support and training (Audit Scotland, 2016a).

Factors that will impact on workforce planning include:

- Financial pressures on the NHS and local authorities with concerns that future changes to the workforce will not affect health and care staff equally.
- Difficulties in recruiting and retaining social care staff and the need to develop a “valued, stable, skilled and motivated workforce” (p34).
- The ability to involve voluntary and private sector organisations in workforce planning and the impact of the national living wage on these organisations.

There is scope in the legislation for integration authorities to directly employ staff, with the approval of Scottish Ministers. If achieved, this could address some of the potential challenges of working with two separate workforces, with different terms and conditions and structures.

General Practitioners

GP involvement and a shared vision have been identified as an enabler to successful integration (Burgess, 2012). Audit Scotland (2015) notes that there are concerns about GPs having time to actively contribute to the success of integrated services and a risk that GPs will continue to refer people to hospital if there are concerns around the quality or accessibility of community based services.

The Royal College of General Practitioners (RCGPs) in Scotland has expressed concerns that GPs do not feel engaged by IJBs and have had little input to develop or influence the system and are not knowledgeable about the forthcoming changes (Holyrood Magazine, 2015). In its 2016 manifesto the RCGPs calls for:

1. IJBs to initiate urgent and adequate engagement with general practice, beginning with the development of specific planning groups.
2. The utilisation of the developing structure of GP clusters within localities.
3. Appropriate time and funding to be made available for GPs involved in the process and in the subsequent work of providing satisfactory integrated care.
4. The development of social prescribing, such as that provided by Links practitioners, to allow people to access non-pharmacological services where these would be beneficial to their wellbeing.
REPORTING PERFORMANCE

The integration of health and social care aims to shift care towards preventative and community based services. However, there are questions about how well the core integration indicators will measure progress in transferring care from hospital to a community setting. These indicators are being revisited to focus more on primary care, secondary care and children’s health and social care (Scottish Government, 2016b). Audit Scotland (2015) noted that it is unclear how the Scottish Government will track savings from integration. Audit Scotland also identified that there may be difficulties comparing the performance of different integration authorities which could hamper effective benchmarking.

SHARING GOOD PRACTICE

There may be a desire to reflect and share good practice. However, the high level of variation in how the integration authorities are being established and developed might make this challenging.

COMPLAINTS

When a joint board model has been adopted, the NHS board and local authority will remain responsible for the delivery of health and social care services. Complaints about service delivery will continue to be dealt with through existing procedures. Arrangements for the management of complaints relating to integrated service delivery should be set out in the integration schemes. The Scottish Government noted that arrangements for complaint handling in an integrated context should follow the Scottish Public Services Ombudsman (SPSO) Model Complaints Handling Guidance (Scottish Government, 2015b).

NEXT STEPS

From April 2017, the Care Inspectorate and Healthcare Improvement Scotland are required to assess progress in establishing joint strategic commissioning and the early impact of integration (Audit Scotland, 2015).

THE HEALTH AND SPORT COMMITTEE

As part of its consideration of the Scottish Government’s draft budget the Scottish Parliament Health and Sport Committee will focus on the integration of health and social care budgets. The Committee has issued a survey questionnaire to all integration authorities to gather information on the initial stages of operation. This will be followed by oral evidence from integration authorities and an evidence session with the Scottish Government on the wider health budget.

<table>
<thead>
<tr>
<th>Health Board Expenditure</th>
<th>Scotland Total</th>
<th>Estimated expenditure on delegated functions</th>
<th>Proportion of Scotland total expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital services</td>
<td>5,776</td>
<td>1,970</td>
<td>34.1%</td>
</tr>
<tr>
<td>Community Health Services</td>
<td>1,760</td>
<td>1,479</td>
<td>84.0%</td>
</tr>
<tr>
<td>Family Health Services</td>
<td>2,463</td>
<td>2,463</td>
<td>100.0%</td>
</tr>
<tr>
<td>Resource Transfer from health boards to local authorities</td>
<td>356</td>
<td>356</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Total Health Board Expenditure</strong></td>
<td><strong>10,355</strong></td>
<td><strong>6,268</strong></td>
<td><strong>60.5%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Work Expenditure</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Older Persons</td>
<td>1,372</td>
<td>1,372</td>
<td>100.0%</td>
</tr>
<tr>
<td>Children</td>
<td>870</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other Adults</td>
<td>865</td>
<td>865</td>
<td>100.0%</td>
</tr>
<tr>
<td>Other Social Work</td>
<td>10</td>
<td>10</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Total Social Work</strong></td>
<td><strong>3,117</strong></td>
<td><strong>2,247</strong></td>
<td><strong>72.1%</strong></td>
</tr>
</tbody>
</table>

**Total Health & Social Care Expenditure** | **13,116**     | **8,159**                                     | **62.2%**                               |

Source: Scottish Government (personal communication).
ANNEX B: INTEGRATION INDICATORS:

The 23 integration indicators are grouped into two types of measures:

Outcome indicators based on survey feedback:
- Percentage of adults able to look after their health very well or quite well.
- Percentage of adults supported at home who agree that they are supported to live as independently as possible.
- Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
- Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
- Percentage of adults receiving any care or support who rate it as excellent or good
- Percentage of people with positive experience of care at their GP practice.
- Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
- Percentage of carers who feel supported to continue in their caring role.
- Percentage of adults supported at home who agree they felt safe.
- Percentage of staff who say they would recommend their workplace as a good place to work.

Indicators based on organisational data:
- Premature mortality rate.
- Rate of emergency admissions for adults.
- Rate of emergency bed days for adults.
- Readmissions to hospital within 28 days of discharge.
- Proportion of last 6 months of life spent at home or in community setting.
- Falls rate per 1,000 population in over 65s.
- Proportion of care services graded ‘good’ (4) or better in Care Inspectorate Inspections.
- Percentage of adults with intensive needs receiving care at home.
- Number of days people spend in hospital when they are ready to be discharged.
- Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.
- Percentage of people admitted from home to hospital during the year, who are discharged to a care home.
- Percentage of people who are discharged from hospital within 72 hours of being ready.
- Expenditure on end of life care.


RELATED BRIEFINGS

SB 12-48 Integration of Health and Social Care: International Comparisons

SB 13-15 Public Bodies (Joint Working) (Scotland) Bill

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