Survey of 2017-18 Integration Authority budget plans

Context
In previous years, the Health and Sport Committee has undertaken surveys of NHS Board budget plans in order to provide a more in-depth analysis of health spending plans. This reflects the fact that, at the time of the draft budget, there is no information available on the spending plans of the boards. The draft budget only provides information on the planned allocations to the boards but no detail below this; meaning that for more than three-quarters of the total health budget, there is no detailed information on its planned use. The budget scrutiny that takes place following the publication of the draft budget cannot therefore provide an in-depth examination of spending plans at local level.

As 2016-17 is the first full year of operation of the new integration authorities (IAs), the Health and Sport Committee agreed to undertake a survey of the 31 IAs\(^1\) to highlight any emerging issues and provide a benchmark for any future inquiries in this area. A copy of the survey is included as an Appendix to this paper. Replies were received from all 31 IAs and some follow up information was requested from several authorities.

This report summarises the responses received and is structured as follows:

1. IA budgets
2. Budget setting process
3. Social Care Fund
4. Efficiency savings
5. Shifting the balance of care
6. Scope of delegated functions
7. Performance framework indicators

---

\(^1\) There are 30 Integrated Joint Boards (IJBs) and one integration authority (Highland) which operates under a different model, known as the lead agency model. The term Integration Authority is used in this paper where both types of models are being referred to.
1. IA budgets

In most commentary and documents relating to integration, the size of the combined budget to be delegated to IAs has usually been described as ‘almost £8bn’.\(^2\) As a result of delays in finalising IA budgets, it has not been possible to provide any update to this figure until now. The survey asked IAs to provide details of their 2016-17 budgets along with equivalent data for 2015-16. The survey results show that IAs are managing budgets totalling around £8.2bn in 2016-17. In responding to the survey, some IAs did not provide details of their set aside budgets\(^3\), so this figure may underestimate the final total once set aside budgets have been agreed. The Scottish Government has also collected budget data from IAs and their data also show total budgets of £8.2bn.

As shown in Figure 1, over two-thirds (70%) of the £8.2bn total is coming from health boards (including set aside budgets). Local authorities account for just under a third of the total IA budgets. This breakdown is also consistent with the Scottish Government figures.

**Figure 1: 2016-17 Integration Authority budgets, £m**

![Figure 1 showing budget distribution](image)

Figure 2 shows how these proportions vary across IAs. The IAs are ranked according to the proportion of the total budget accounted for by the local authority. This ranges from 22% in Argyll and Bute, South Lanarkshire and Dumfries and Galloway to 52% in Orkney, compared with the Scottish average of 30%. Highland has been excluded from this chart as the different operating model in Highland affects comparisons.

Some of the differences will reflect:

---


\(^3\) The set aside budget is the IJB’s share of the budgets for delegated acute services provided by large hospitals on behalf of the IJB
- Differing scope of the IJB functions e.g. some local authorities have delegated children’s social care, others have only delegated adult services;

- Different approaches to hospital services – some health boards have delegated more than the minimum scope of hospital specialties e.g. Dumfries & Galloway and Argyll & Bute have delegated all of their hospital budgets;

- Different approaches to set aside budgets – some health boards (Orkney, Dumfries & Galloway and Argyll & Bute) have delegated their hospital budgets as payments to the IJB (i.e. have no separately identified set aside budget).

- Budgets for hosted services have been included in the host partnership in some cases (hosted services are those provided in one area for patients in another area, often specialist services)

**Figure 2: 2016-17 Integration Authority budgets, % of total**

![Bar chart showing the distribution of budgets by integration authority in Scotland](chart.png)
IAs were also asked to split their budget across four broad areas:

- Hospital
- Community healthcare
- Family health services and prescribing
- Social care

These categories were chosen as they reflect those used by the Scottish Government in its budget analysis, so it was hoped that IAs would find it easy to report against these headings and that results would be consistent across IAs. Figure 3 shows how the total budget was split across these areas. Again, these figures are broadly consistent with those collected by the Scottish Government, although there appear to be some minor differences in the allocation between family health services and community healthcare.

Figure 3: Allocation of 2016-17 IA budgets across service areas, %

A third of the budget is allocated to social care, just over a quarter to family health services and prescribing and a fifth to both community healthcare and hospital services. Again, these proportions vary considerably between IAs, as shown in Figure 4. In South Lanarkshire and Dumfries and Galloway, only 22% of the budget is allocated to social care, while the equivalent proportion for Orkney is 52%. Some of this will be explained by differences in the scope of delegated functions – neither South Lanarkshire or Dumfries and Galloway have delegated children’s social care, while Orkney and others have. In addition, the Scottish Government has advised that Orkney has materially understated its hospital budgets, which will affect its figures. (Note that Scottish Borders did not provide a full breakdown of planned expenditure, so the split shown is between social care and healthcare.)
2. Budget setting process

IAs were asked when they had agreed their 2016-17 budgets. Of the 31 IAs, only 11 had finalised their budgets prior to the start of the financial year. A further 9 had agreed their budgets by June; and another 8 by September. Three IAs (Edinburgh, Renfrewshire and South Ayrshire) stated that, at the time of responding to the survey, they had yet to agree a final budget.

Most IAs felt more optimistic about timescales for agreeing their 2017-18 budgets, with 22 expecting to finalise their 2017-18 budgets before the end of March. Four IAs expected to finalise their budgets between April and June, while 5 did not give an expected date, with several noting that it would depend on the timing of the Scottish Government settlements, particularly for the health boards.
IAs were asked to provide details of any challenges they had faced in agreeing their 2016-17 budgets. A number of common themes emerged from the responses to this question:

- The different budget cycles of health boards and local authorities were mentioned by more than half of respondents. Local authority settlements are usually agreed in December, but health board allocations are usually agreed in February. This difference in timescales presented challenges in agreeing IA budgets prior to the start of the financial year.

- Issues relating to efficiency savings were also mentioned by more than half of respondents. Where details were given, this often related to the scale of efficiency savings required by the health boards, often falling most heavily on services delegated to the IJB. The scale of the required savings and the fact that the details of where these efficiencies would be found were sometimes unclear meant that the IJBs were then faced with levels of risk that they felt unable to accept. This resulted in budgets not being signed off until further clarity was available.

- More than a third of respondents noted that the £250m social care fund had created challenges for budget setting. Respondents stated that the timing of the allocation and initial lack of clarity as to how it was to be used resulted in delays in finalising their budgets. (There is further discussion of the social care fund later in this paper.)

- A number of IJBs had found adapting to the new arrangements challenging and felt that the intended operational independence of the IJB had not been achieved:
  - East Dunbartonshire noted that “the health and social care partnership need absolute autonomy to agree the funding allocation. In the early years, there is a general lack of understanding across the board which requires wider awareness training."
  - North Ayrshire commented that “both partners continue to operate individually for budget setting purposes…which impacts on the investment which can take place. Direct funding of IJBs by Scottish Government would remove these cross sector barriers"
  - North and South Lanarkshire both commented on the interdependencies of decisions and the challenges this presents for budget setting. Using the example of hosted care services, both IJBs noted “the budget allocation between the IJBs is currently based on an agreed percentage split….If the host IJB subsequently chooses to take a differential savings/uplift level on the funding, then the amount to be recharged to the other IJBs may vary. The health board would not be able to calculate the impact of this during the budget setting process."
  - East Renfrewshire noted that “…the funding allocations [do not] reflect 10 years of integration” and said there was no mechanism for transferring funds from secondary to primary care.
Edinburgh commented that the local authority and health board had separately determined their contributions, which did not give sufficient recognition to the IJB financial plans. Edinburgh hoped that this process would evolve so that IJB financial plans were better reflected in 2017-18 budget setting. Scottish Borders made similar observations.

- Other issues that were raised by fewer respondents included:
  - Agreeing budgets for GP prescribing, including planned savings in this area
  - Agreeing the set aside budget
  - Planning services with only a one year budget timeframe
  - Managing reductions in the budgets for Alcohol and Drug Partnerships

IAs were also asked whether they had set in place any changes to address challenges faced in the current year. The majority of respondents noted that they had introduced changes to processes to help address the issues they had faced, in particular in respect of timing differences in health board and local authority budget cycles. However, several noted that there was only a certain amount that they could do to address this and that, unless the more fundamental issue of the timing of Scottish Government allocations was changed, the challenges would remain.

Two IJBs (Renfrewshire and Aberdeen City) made specific reference to their NHS partners having introduced changes to their budget planning so as to be better aligned with the local authority timescales. A number also referred to their Transformation Programmes that would help inform the identification of efficiency savings, an area that had been particularly problematic for many IJBs.

3. Social care fund

In its 2016-17 draft budget, the Scottish Government announced a £250m social care fund to be allocated to IAs (via health boards) specifically to address social care. The Scottish Government allocated the £250m across the IAs. In a letter to COSLA, John Swinney set out the requirements in relation to the use of this funding:

- 50% to support additional spend on expanding social care, including through making progress on charging thresholds for all non-residential services to address poverty.
- 50% to help meet a range of existing costs faced by local authorities in the delivery of effective and high quality health and social care services in the

---

context of reducing budgets, including delivery of the Living Wage for all social care workers.

As noted in the previous section, many IAs said that the £250m social care fund had created challenges for them in agreeing their budgets. This was primarily the result of the late timing of the allocation of the funds (February 2016) and the initial lack of clarity in the guidance on how the funds were to be used.

The survey asked for details of how IAs had used their allocation from the £250m social care fund. Some IAs did not provide a detailed breakdown of the use of their share of the £250m fund. In addition, some simply noted that the funds had been split 50-50 according to the Scottish Government guidelines, as summarised above.

Around half of respondents provided a detailed breakdown of their use of their allocation from the social care fund. In total, these IAs accounted for 45% of the £250m total fund. For these IAs:

- Just over a quarter (28%) of the funding had been used to fund the implementation of the living wage commitment to social care workers
- Just under a third (32%) had been used to address increasing levels of demand in social care, including as a result of demographic pressures. Services highlighted included mental health services, learning disability services and services for older people
- Other smaller amounts had been used to fund:
  - uplifts in the national care homes contract price
  - pay inflation for council staff (including national insurance contributions)
  - uplifts in income thresholds for charging for services
- A few IAs made reference to use of the funds to reduce the council’s contribution to the IJB budget (Aberdeenshire, Argyll and Bute, Highland and West Dunbartonshire)

Edinburgh IJB noted that the City of Edinburgh Council’s offer in relation to the application of their share of the social care fund did not comply with the Scottish Government guidance and that they were working to resolve this. It was not clear from the response how the use of the funds failed to meet with the requirements.

Highland noted that the guidance in relation to the use of the social care fund was aimed towards the IJB model and did not reflect the lead agency model in place in the Highlands.

East Dunbartonshire noted that the allocation of ring-fenced funding, such as the social care fund undermined the intention that “money loses its identity” that the legislation was seeking to embed.
4. **Efficiency savings**

IAs were asked what efficiency savings they were planning to deliver in 2016-17. For the 27 IAs that provided details, planned efficiency savings in 2016-17 averaged 2.5% of their total budgets. However, this varied widely between IAs:

- Four IAs were planning efficiency savings of 1% of their budgets or less (Aberdeenshire, East Dunbartonshire, Fife and Moray)
- Three IAs were planning efficiency savings of more than 4.5% of their budgets (Edinburgh, Dumfries and Galloway and Scottish Borders)

Eleven IAs provided a breakdown showing whether planned efficiencies were from the health board or the council budgets. For this group as a whole, just over half of planned efficiencies (57%) were from health boards, with 43% from council budgets. Again, the picture varied widely across the country. In Aberdeen City, 75% of planned efficiencies were from the council budget, while in Fife and the Western Isles, only 12% and 13% respectively of savings were coming from the council budget.

5. **Shifting the balance of care**

IAs were asked to provide details of up to three examples of how they were planning to shift resources as a result of integration over the period of their Strategic Plan. Although it is too early to expect to see any clear shift in resources from hospital to community care, the survey asked about how IAs would plan to achieve this over the longer term.

Many IAs gave very broad descriptions of how they would plan to shift resources, listing investment in areas such as:

- Investment in prevention and early intervention
- Community-based support
- Reducing delayed discharge
- Third sector partners
- Development of care pathways
- Use of technology to deliver savings
- Development of rehabilitation teams
- Reablement services

A few IAs gave more specific examples of their plans (although few gave any indication of the value of resources devoted to these projects).

- Edinburgh cited:
- the closure of Liberton hospital and the resulting provision of services within the community, including the development of new domiciliary care contracts
- the introduction of a rapid response function for older people to support the reduction in the number of inpatient beds at the new Royal Edinburgh Hospital
- the modernisation of learning disability services and closure of Murray Park resulting in a shift from hospital to community based care

- Highland and Midlothian both referred to the development of specialist housing to help address complex care needs within the community
- North Ayrshire provided a specific example of a £600,000 investment in its ‘Care at Home Reablement Service’. This was estimated to have saved 4,710 acute bed days and was the only example given in the survey responses of a specific saving resulting from investment (although the financial value of the bed days saved was not given).
- North Lanarkshire referred to redesign of its IV drug treatment service so that it can be delivered within homes rather than in hospitals, both releasing hospital resources but also improving accessibility for those with transport or mobility issues
- Western Isles described in broad terms how they would hope to achieve a shift in resources, but also provided a chart which showed an identifiable shift even by 2018-19:

![Anticipated shift in resources (£m): 2016/17 - 2018/19](image)

Highland stated that, as a result of four years of integration, there has been a shift in resource from institutional care to home-based care and that they would expect this shift to continue. However, no data was provided to support this statement. Highland also noted that the “artificial divide” of budgets has now gone.
After listing areas where it would plan to invest to achieve a shift in resources, Renfrewshire noted:

“It is vital to recognise that, whilst these initiatives may prove that resource and activity shifts can be made, releasing resources say from acute services has proved difficult. Given the financial pressures and funding shortfalls being faced, it is likely that any released resources may be needed to deliver financial balance rather than to fund transfers of service or activity.”

Orkney noted:

“As a very small area, with a hospital that cannot be further reduced in size and a demographic profile that presents some of the biggest challenges in Scotland in terms of increasing number of older age, older people, we have very limited scope to make significant resource shifts from hospital to other forms of care. We have also been working in partnership between the Council and NHS for a number of years and have already made a great deal of the changes and shifts that are available. The task at hand therefore presents a significant challenge.”

6. Scope of delegated functions

IJBs were asked whether they had any plans to extend the range of functions delegated to the IJB (this question was not relevant to Highland due to its use of a lead agency model). Many noted that the functions delegated to the IJB already extended beyond the minimum scope set out in the regulations. The majority had no immediate plans to extend the scope of the IJB functions, although a few noted that some functions were under review, with the possibility for inclusion at a later date:

- Aberdeen City – acute inpatient mental health services and learning disability services
- Dumfries and Galloway – high cost care packages provided outwith the region; community dental services and family health services
- Glasgow – hospices and end of life care; residential elements of continuing care beds
- Renfrewshire – hospices
- West Dunbartonshire - hospices

7. Performance framework

The IAs were asked to provide details of the indicators that they will be using to monitor performance and demonstrate their linkage to the nine national outcomes. Only one IA (Orkney) failed to provide any details of the performance framework it was planning to use, although they said that the framework was under development. All other IAs provided details of their performance framework (for some, the framework was still under development). The majority of IAs were making use of the 23 national indicators against which IAs will be required to report. Where these were not mentioned, or were not listed in full, it was not clear whether the IAs had taken it
as read that these would be included, so only chose to list the additional indicators that they were planning to use.

Twenty-three of the IAs also gave details of additional local indicators that they are planning to use. Around half of these IAs are planning to use between 50 and 100 additional local indicators to monitor performance. Several IAs noted that their performance frameworks were still under development.

IAs were also asked to show how their budgets linked to the national outcomes. They will be required to do this as part of their financial reporting. Only one IA (Aberdeenshire) made any attempt to link budgets to the performance framework, although the linkage was to strategic priorities rather than the national outcomes. In some cases, the framework only referred to the ‘core budget’ rather than giving details of the budgets allocated. Nonetheless, it was the only example of any attempt to link budgets and outcomes. Scottish Borders and Clackmannanshire and Stirling stated that they were working towards achieving this linkage during the current financial year. Moray also noted that work was underway in this area.

No other IAs gave any budgetary information alongside their performance framework. Many noted that they were unable to do this, while others just left the table blank. A few specifically noted the challenge they faced in providing such information. For example:

- **Angus** said: “Our budget is not set up to be aligned to the national outcomes. We are not clear how this could be achieved.”

- **Inverclyde** noted: “It is unlikely that budgets will be able to be linked accurately to the outcomes in future, as efficient spend will mean that the same money will in most cases contribute to the delivery of multiple outcomes. The strength of the outcomes lies in their presentation as a suite of requirements that together shape a person-centred approach, so it would be counterproductive to try to separate them out to ascribe levels of spend to the delivery of individual outcomes.”

- **North Ayrshire** stated: “It is not possible to link budgets to these outcomes. Although as an organisation we are committed to meet these outcomes, our budget management system is not set up to record budgets or spends against these national outcomes. If budgets and spend are to be monitored in this way moving forward further developments of our systems would be required to capture this data”.

- **Midlothian** said: “...it is not possible to analyse the budgets used in the delivery of the outcomes. Budgets are held at service level and many services deliver a range of outcomes....as required on an individual person (patient or client) basis as those people’s needs are supported.”
The Committee has chosen to consider the integration of health and social care as part of its consideration of the Scottish Government’s budget. The following questions are designed to explore the budget setting process for 2016-17 and how budget allocation reflects the priorities set out in the performance framework.

1. Which integration authority are you responding on behalf of?

2. Please provide details of your 2016-17 budget:

<table>
<thead>
<tr>
<th></th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health board</td>
<td></td>
</tr>
<tr>
<td>Local authority</td>
<td></td>
</tr>
<tr>
<td>Set aside budget</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
</tr>
</tbody>
</table>

3. Please provide a broad breakdown of how your integration authority budget has been allocated across services, compared with the equivalent budgets for 2015-16.

<table>
<thead>
<tr>
<th></th>
<th>2015-16</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community healthcare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family health services &amp; prescribing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social care</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. The 2016-17 budget allocated £250m for social care. Please provide details of the amount allocated to your integration authority and how this money has been utilised.
Budget setting process

5. Please describe any particular challenges you faced in agreeing your budget for 2016-17

6. In respect of any challenges detailed above, can you describe the measures you have put in place to address these challenges in subsequent years?

7. When was your budget for 2016-17 finalised?

8. When would you anticipate finalising your budget for 2017-18?

Integration outcomes

9. Please provide up to three examples of how you would intend to shift resources as a result of integration over the period of your Strategic Plan:

10. What efficiency savings do you plan to deliver in 2016-17?
11. Do you anticipate any further delegation of functions to the integration authority? (If so, please provide details of which services and anticipated timescales)

**Performance framework**

12. (a) Please provide details of the indicators that you will use to monitor performance and show how these link to the nine national outcomes

(b) If possible, also show how your budget links to these outcomes

<table>
<thead>
<tr>
<th>National Outcome</th>
<th>Indicators</th>
<th>2016-17 budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>People are able to look after and improve their own health and wellbeing and live in good health for longer.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People who use health and social care services have positive experiences of those services, and have their dignity respected.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and social care services contribute to reducing health inequalities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Outcome</td>
<td>Indicators</td>
<td>2016-17 budget</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>People who provide unpaid care are supported to look after their own health and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>wellbeing, including to reduce any negative impact of their caring role on their</td>
<td></td>
<td></td>
</tr>
<tr>
<td>own health and wellbeing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People who use health and social care services are safe from harm.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People who work in health and social care services feel engaged with the work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>they do and are supported to continuously improve the information, support,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>care and treatment they provide.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resources are used effectively and efficiently in the provision of health and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>social care services.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>