HEALTH AND SPORT COMMITTEE

AGENDA

7th Meeting, 2016 (Session 5)

Tuesday 4 October 2016

The Committee will meet at 10.00 am in the James Clerk Maxwell Room (CR4).

1. **Subordinate legislation:** The Committee will consider the following negative instrument—

   The General Dental Council (Fitness to Practice) (Amendment) Rules Order of Council 2016 (SSI 2016/902)
   Food Hygiene (Scotland) Amendment Regulations 2016

2. **Health and Social Care Integration budgets:** The Committee will take evidence from—

   Rob McCulloch-Graham, Chief Officer, Edinburgh Health and Social Care Partnership;

   Val de Souza, Director, South Lanarkshire Health and Social Care Partnership;

   Nick Kenton, Director of Finance, NHS Highland;

   David Robertson, Chief Financial Officer, Scottish Borders Council and Member of the Executive Management Team, Scottish Borders Health and Social Care Partnership.

3. **Health and Social Care Integration Budgets (in private):** The Committee will consider the main themes arising from the oral evidence heard earlier in the meeting.

4. **Delayed Discharges (in private):** The Committee will consider its conclusions.
David Cullum
Clerk to the Health and Sport Committee
Room T3.60
The Scottish Parliament
Edinburgh
Tel: 0131 348 5210
Email: david.cullum@parliament.scot
The papers for this meeting are as follows—

**Agenda item 1**

Note by the clerk  
HS/S5/16/7/1

**Agenda item 2**

PRIVATE PAPER  
HS/S5/16/7/2 (P)

IJB Submissions - Budget Scrutiny  
HS/S5/16/7/3

Survey analysis Integration authority budget plans  
HS/S5/16/7/4

**Agenda item 4**

PRIVATE PAPER  
HS/S5/16/7/5 (P)
Health and Sport Committee
7th Meeting, 2016 (Session 5), Tuesday, 4 October 2016
Subordinate Legislation Briefing

Overview of instruments
1. There are two negative instruments for consideration at today’s meeting:
   - The General Dental Council (Fitness to Practice) (Amendment) Rules Order of Council 2016 (SSI 2016/902)
   - Food Hygiene (Scotland) Amendment Regulations 2016

The General Dental Council (Fitness to Practice) (Amendment) Rules Order of Council 2016 (SSI 2016/902)

Background
2. The policy behind this instrument is to enable the General Dental Council to take timely, fair and proportionate action through their fitness to practice processes when dental professionals do not meet the required standards. The Policy Note is available at Annexe A.
4. There has been no motion to annul this instrument.
5. The Committee needs to report by 31 October.

Delegated Powers and Law Reform Committee consideration
6. The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 20 September 2016. The Committee determined that it did not need to draw the attention of the Parliament to this instrument on any grounds within its remit.
Food Hygiene (Scotland) Amendment Regulations 2016

Background

7. These Regulations amend the Food Hygiene (Scotland) Regulations 2006 ("the Principal Regulations") implementing Commission Implementing Regulation (EU) No. 2015/1375 ("the Codification Regulation") which codifies certain provisions laying down specific rules on official controls for *Trichinella* in meat. The Policy Note is available at Annexe B.


9. There has been no motion to annul this instrument.

10. The Committee needs to report by 31 October.

Delegated Powers and Law Reform Committee consideration

11. The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 27 September 2016. The Committee determined that it did not need to draw the attention of the Parliament to this instrument on any grounds within its remit.
ANNEXE A

POLICY NOTE

THE GENERAL DENTAL COUNCIL (FITNESS TO PRACTISE) (AMENDMENT) RULES ORDER OF COUNCIL 2016

2016 No. 902

The above Instrument was made in exercise of powers conferred by sections 27(6A), 27A(13), 27AA, 27AB(1), 36N(6A), 36O(13), 36OA, 36OB(1), 50C(5) and (6) of, and paragraph 2(1)(b) of Schedule 3 and paragraph 2(1)(b) of Schedule 4B to the Dentists Act 1984. The Instrument is subject to negative procedure.

Background

1. The rules scheduled to and approved by this Instrument, amend General Dental Council (GDC) Rules in relation to fitness to practise, education, registration and registration appeals. These Rules have been made by the GDC in exercise of powers conferred by the Dentists Act 1984 (“the Act”). The 1984 Act was amended this year by the General Dental Council (Fitness to Practise etc) Order 2016 (S.I. 2016/496) (“the 2016 Order”), which came into force on 13th April 2016.

2. The provisions in the 1984 Act relate to the regulation of dentists and dental care professionals (clinical dental technicians, dental hygienists, dental nurses, dental technicians, dental therapists, and orthodontic therapists) by the GDC and are reserved to Westminster. Those relating to regulation in Scotland of dental nurses, dental technicians, clinical dental technicians and orthodontic therapists are considered to fall within the legislative competence of the Scottish Parliament. This is because these professions have been regulated since the coming into force of the Scotland Act 1998.

Policy Objective

3. The policy behind this instrument is to enable the GDC to take timely, fair and proportionate action through their fitness to practise processes when dental professionals do not meet the required standards.

4. The Instrument provides the GDC with new powers in respect of fitness to practise functions and include:

   • To provide for Case Examiners to consider allegations of impairment of fitness to practise and decide how a case should proceed at the end of the investigation stage of the fitness to practise process. It is anticipated that this will lead to the swifter resolution of fitness to practise cases.

   • To give Case Examiners power to agree undertakings with registrants (a current function of the Investigating Committee). This means in appropriate cases, instead of referring a person to a full fitness to practise hearing, they can instead agree with the registrant, certain conditions of practise.
• To provide for the review of cases closed at the end of the investigation stage.
• To provide for the review of a determination that an allegation does not amount to an allegation of impairment of fitness to practise.
• To review a decision to issue a warning to a registrant.

6. Further details on the proposed changes are set out in the attached Department of Health Explanatory Memorandum, in paragraph 7, headed “policy background”.

Consultation

7. The GDC carried out a public consultation between 17 November 2014 and 12 January 2015. An online consultation survey was published on the GDC’s website at:

http://gdc-uk.org/GDCcalendar/Consultations/Pages/Consultationon-changes-to-the-GDCs-Fitness-to-Practise-Rules-2006.aspx

and a number of interested parties were informed, including patient groups, professional bodies and trades unions, and employers, on 17 November 2014.

8. The GDC received 11 responses from organisations and 30 from individuals. The proposals were generally well supported and there were no major areas of disagreement. The majority of the 41 respondents to the consultation were supportive of the proposals and considered that the changes would produce significant improvements to the way GDC manages cases (key points detailed in paragraphs 8.5 – 8.9 of the DH Explanatory Memorandum).

Guidance

9. The GDC will publish guidance on its website in relation to the measures introduced by the Instrument including an explanation of undertakings and when they might be agreed and of the role the Case Examiners will have within the GDC’s regulatory regime. Guidance will also be drafted specifically for the Case Examiners explaining their functions and role in greater detail (these guidance documents will also be published). Information will be provided to those registrants who are given a warning following an investigation on the procedure for seeking a review. Information about the review process as it applies at other decision points will be provided to both complainants and registrants.

Impact Assessment and Financial Implications

10. The impact on business is expected to be beneficial. An impact assessment was carried out and submitted in respect of the 2016 Order (S.I. 20016/496). This indicated a net benefit to business over 10 years of approximately £21 million, approximately 2m per annum. There is no impact on the public sector, charities or voluntary bodies.

Monitoring and Review

11. The Professional Standards Authority for Health and Social Care (PSA) conducts annual performance reviews of each of the health and care professional regulatory bodies. It is anticipated the PSA, when performing such reviews, will take into account the changes to the fitness to practise procedures introduced by this Instrument and provide insight into the effect of these measures. The
department will also keep these measures in view as part of its role in
developing and maintaining the professional regulatory landscape.
1. Description
The Scottish Ministers make the following Regulations in exercise of the powers conferred by section 2(2) of, and paragraph 1A of Schedule 2 to the European Communities Act 1972 and all other powers enabling them to do so.

2. Policy Objective

3. Policy Background
In June 2015 the European Commission put forward a proposal that Regulation (EC) No 2075/2005 and all of its amendments go through a codification process in order to create a new Regulation that consolidates the previous version and all of its amendments. The proposal was welcomed by Food Standards Scotland and the pig meat industry as the codification provides more simplified instruction to industry.

The new Commission Regulation repealed Regulation (EC) No 2075/2005 as amended and consolidated the provisions at EU level that have applied since 2005 remaking them in the new codified Commission Regulation. This codification includes minor changes to the specific rules on the controls for *Trichinella* that were initially made in Commission Implementing Regulation (EU) No 1114/2014. These changes introduced two new flexibilities; the first allows horse carcases to be cut into a maximum of six parts in slaughterhouses or in a cutting plant on the same premises pending results from *Trichinella* testing. The second is the introduction of an additional testing method for *Trichinella* in domestic swine.

4. Consultation
A shortened four week consultation was carried out in Scotland on the draft SSI from 25 November to 23 December 2015. No responses were received.

5. Other Administrations
These Regulations apply to Scotland only and corresponding Regulations will be introduced in the other UK countries.

6. Impact Assessment
A Business and Regulatory Impact Assessment (BRIA) has not been prepared to accompany these Regulations as it consolidates existing legislation, the latest of which was the subject of a full assessment in 2014, and does not change the requirements. As the interpretation of the Regulation remains the same and the
flexibilities have no negative impact on Scottish practices, a further BRIA is not required.

7. Regulating small businesses
This legislation applies to small business in the same manner as to larger businesses.

8. Monitoring
Food Standards Scotland (FSS) will work with Enforcement Authorities where problems or suspected infringements of the legislation arise. The effectiveness of this instrument will be monitored by FSS via general feedback from industry and Enforcement Authorities.
Edinburgh Integration Joint Board

Budget Scrutiny: Integration Authorities

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?
   Edinburgh Integration Joint Board

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>318.1</td>
</tr>
<tr>
<td>Local authority</td>
<td>185.2</td>
</tr>
<tr>
<td>Set aside budget</td>
<td>93.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>596.5</strong></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 Outturn</th>
<th>2016-17 Anticipated spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>Community healthcare</td>
<td>110.4</td>
<td>110.0</td>
</tr>
<tr>
<td>Family health services &amp; prescribing</td>
<td>149.3</td>
<td>150.2</td>
</tr>
<tr>
<td>Social care</td>
<td>227.4</td>
<td>235.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>598.0</strong></td>
<td><strong>602.3</strong></td>
</tr>
</tbody>
</table>

The table above compares the actual spend for last financial year with the anticipated spend for this year. The difference of £5.8m is the IJB’s share of the £20m deficit in the NHS Lothian financial plan submitted as part of the Local Delivery Plan in May 2016. The actual budget offer from NHS Lothian is £596.5m as per table in 2 above.

It should be noted that, despite the welcome introduction of the social care fund, the total monies available to the IJB are potentially less than the actual spend in 2015-16, reflecting the financial pressures we are facing.
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.

<table>
<thead>
<tr>
<th>Demography - learning disabilities</th>
<th>Growth £m</th>
<th>Pressures £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demography - older people</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td>Charging thresholds</td>
<td>3.5</td>
<td></td>
</tr>
<tr>
<td>Service redesign</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>Implementation of living wage</td>
<td>3.7</td>
<td>1.3</td>
</tr>
<tr>
<td><strong>Available funding</strong></td>
<td><strong>10.1</strong></td>
<td><strong>10.1</strong></td>
</tr>
</tbody>
</table>

**Budget setting process**

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

We are yet to formally accept the delegated budgets proposed by NHS Lothian (NHSL) and the City of Edinburgh Council (CEC), however are proceeding on the basis that the outstanding issues will be resolved. Specifically these are:

- **NHSL** – this offer is based on a financial plan which is out of balance by £20m, with the IJB’s share of this gap being £5.8m. The places NHS Lothian in a position where it cannot currently deliver services within the funding directed by the IJB making it difficult for the IJB to accept. We continue to work with NHS Lothian to identify how this deficit is bridged.

- **CEC** – the offer fails the “Swinney test” (designed to ensure that ministerial expectations in relation to the use of the Social Care Fund are met) by a material distance. We are working with colleagues from Scottish Government and CEC to resolve.

In addition to these material issues there are a number of points we would like to bring to the committee’s attention:

- In 16/17 the IJB budget setting process was led by CEC and NHSL who determining the level of funding to delegate. Whilst we recognise that approach was the most appropriate at the time we would expect to see more recognition of IJB financial plans in the process for 17/1;

- Lack of reliable, easily available information on which to base a “fair” methodology for allocating pan Lothian NHS budgets between 4 IJBs was problematic. This is particularly true for budgets for “set aside” services. Whilst we are undertaking further work in this area for 17/18 we have some way to go before determining a workable solution;

- Timescales of council and NHS budget setting processes are not currently well aligned;
• NHS financial planning process did not conclude until May 2016, the date at which financial plans had to be submitted to the Scottish Government;
• Emphasis on a 1 budget settlement does not support IJBs develop a financial framework to support the 3 year strategic plan;
• Whilst we welcome the additional funding via the social care fund, the associated conditions and prevailing financial climate have made it difficult to sufficiently resource the support required to full pump priming of change;
• The inherent financial pressures in the system mean that, despite the social care fund investment referred to above, we still have a significant savings target; and
• Managing the reductions required in substance misuse service delivery because of budget reductions while achieving an increased focus on recovery focused services.

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?

A number of these actions are reference in the answer to question 5 above. The key continues to be working closely with our partners as the IJB develops. Other actions include:

• Formal agreement in place between the IJB, CEC and NHSL which outlines how we will work together;
• Establishment of a quarterly forum where key issues can be raised and resolved, including areas of contention;

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

See response to question 5 above. The budget is yet to be finalised.

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

We don’t as yet have an agreed timetable but it will be dependent on the overall SG NHS budget setting.

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:

• The closure of Liberton hospital and consequent re provision of services in the community to prevent admission and facilitate timely discharge. This will include increasing support at home through new domiciliary care contracts and re-balance investment within the whole system to reflect this.;
• The introduction of a rapid response function for older people to support the reduction in the number of inpatient beds in the new Royal Edinburgh Hospital; and
• In line with the modernisation of learning disability services the closure of Murray Park will result in a shift from hospital to community based care.

10. What efficiency savings do you plan to deliver in 2016-17?

The agreed savings programme totals £22.2m. A further £5.8m (which represents the IJB’s share of the NHSL financial plan gap) of either cost reductions or additional income would be required to deliver a break even position.

Whilst the IJB has responsibility for the full £22.2m, an element of which will be operationally delivered either through NHSL or one of the other Lothian partnerships. This applies where services are hosted (either by NHSL or one of the other Lothian IJBs) and for set aside services, managed on our behalf by NHS Lothian: in total this accounts for savings of £1.2m, leaving EHSCP with responsibility for delivering savings of £20.9m on behalf of all 4 IJBs.

To support delivery, a programme has been developed which is considered to be achievable although, at this stage, some of the underpinning business cases have still to be completed. The schemes identified are summarised in table 4 below:

<table>
<thead>
<tr>
<th>Savings description</th>
<th>£k</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEC health and social care transformation programme</td>
<td>4,137</td>
</tr>
<tr>
<td>Transformation: organisational review</td>
<td>5,808</td>
</tr>
<tr>
<td>Contract management</td>
<td>1,400</td>
</tr>
<tr>
<td>Minor CEC schemes</td>
<td>130</td>
</tr>
<tr>
<td>Non recurring contribution to offset slippage</td>
<td>3,543</td>
</tr>
<tr>
<td>Service reviews (sexual health, rehabilitation, continence, HBCCC)</td>
<td>990</td>
</tr>
<tr>
<td>Prescribing</td>
<td>1,898</td>
</tr>
<tr>
<td>Reduction in management costs</td>
<td>400</td>
</tr>
<tr>
<td>Supplementary staffing</td>
<td>1,000</td>
</tr>
<tr>
<td>General Medical Services running costs</td>
<td>250</td>
</tr>
<tr>
<td>Edinburgh Drug and Alcohol Partnership</td>
<td>1,380</td>
</tr>
<tr>
<td><strong>Total identified</strong></td>
<td><strong>20,936</strong></td>
</tr>
</tbody>
</table>
11. Do you anticipate any further delegation of functions to the integration authority? (If so, please provide details of which services and anticipated timescales)

Conversations continue with both NHSL and CEC but there are no further decisions on delegations as yet.

South Lanarkshire Health and Social Care Partnership
Budget Scrutiny: Integration Authorities
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.

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

South Lanarkshire Health and Social Care Partnership.

13. 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>300.629</td>
</tr>
<tr>
<td>Local authority</td>
<td>101.743</td>
</tr>
<tr>
<td>Set aside budget</td>
<td>55.154</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>457.526</strong></td>
</tr>
</tbody>
</table>

14. 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>54.231</td>
<td>55.154</td>
</tr>
<tr>
<td>Community healthcare</td>
<td>132.430</td>
<td>149.064</td>
</tr>
<tr>
<td>Family health services &amp; prescribing</td>
<td>146.709</td>
<td>151.565</td>
</tr>
<tr>
<td>Social care</td>
<td>109.132</td>
<td>101.743</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>442.502</strong></td>
<td><strong>457.526</strong></td>
</tr>
</tbody>
</table>

Note:
The Scottish Government allocation for social care in 2016/2017 of £15.210m is included in the community healthcare total of £149.064m.

Resource transfer payments to the local authority are also included in the community healthcare total and excluded from the social care total.

The net expenditure for the social care budget is included in the table above.

15. 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.

The Scottish Government Allocation for Social Care in 2016/2017 is £15.210m and has been allocated as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>2016/2017 Allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support for growth in social care spend</td>
<td></td>
</tr>
<tr>
<td>Care Home Placements</td>
<td>2.300</td>
</tr>
<tr>
<td>Home Care Services</td>
<td>1.450</td>
</tr>
<tr>
<td>Health Care Partnership Priorities</td>
<td>1.885</td>
</tr>
<tr>
<td>Demographic Growth Pressures</td>
<td>1.000</td>
</tr>
<tr>
<td>Extended Integrated Community Support Teams</td>
<td>0.570</td>
</tr>
<tr>
<td>Progress on charging thresholds for all non-residential services to address poverty</td>
<td>0.400</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td><strong>7.605</strong></td>
</tr>
<tr>
<td>Support for local authority health and social care service costs (including the Living Wage for all social care workers).</td>
<td><strong>7.605</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15.210</strong></td>
</tr>
</tbody>
</table>

Budget setting process

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

Earlier notification of the financial settlement for 2016/2017 from the Scottish Government would have been beneficial to the budget setting process for all partners.
In particular, in respect of a number of in-year funding allocations, an assumption had to be made that the previous in year funding allocations would be recurring at the same level. This assumption was necessary as confirmation of the recurring funding allocations available had not been received before the start of the financial year.

It was also not possible to assume that there would be any new in year funding allocations as these had not been announced.

If the current notification arrangements continue for future financial years, it is likely that an indicative budget only can be set for the start of the financial year for the IJB. The indicative budget would then be updated once Scottish Government funding for both partners is confirmed.

In the future, the budget setting process will also be dependent on IJB decisions. For example, in respect of hosted health care services, the budget allocation between the IJBs is currently based on an agreed percentage split. The total funding is then issued by the health board to the host IJB.

If however the host IJB subsequently chooses to take a differential savings/uplift level on the funding, then the amount to be recharged to the other IJB may vary. The health board would not able to calculate the impact of this during the budget setting process unless it had been advised of such decisions by the IJBs.

There is a time lag in getting prescribing data and, historically, the exact allocation of the prescribing budgets to practices is finalised once the full year figures for the previous year are available in June following the March year end. Until this information is available, a provisional estimate is calculated. The prescribing budgets have now been finalised and the updated figures have been incorporated into the above figures.

The identification of efficiency savings was, and continues to be, an ongoing challenge.

The calculation of the notional set-aside budget is based on 2016/2017 prices however only 2014/2015 activity levels are currently available.

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

Financial monitoring arrangements are being established which will inform the strategic commissioning intentions and the future budget requirements.

The timescale for the notification of Scottish Government funding however is outwith the control of the partners.

18. When was your budget for 2016-17 finalised?
A starting budget for 2016/2017 was approved by the Integrated Joint Board in March 2016. It was recognised that further adjustments would be necessary following the approval of health budgets and the progress of the efficiency savings exercise by each partner. The 2016/2017 budget has now been updated.

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

The financial strategy for 2017/2018 is currently being developed.

As highlighted above however, finalising the 2017/2018 budget will be dependent on confirmation of the Scottish Government financial settlement for both the health board and the local authority for 2017/2018.

Integration outcomes

20. 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:

The initial focus is on the following:-

1. Allied Health Professionals
2. Staff groups that were traditionally hospital based are increasingly able to provide care in a community setting as the level of community supports have been increased. Such support includes home care, community nursing and third sector staffing as well as developments in tele-health/tele-care. Key to success will be an integrated approach to care and some success has already been achieved in this respect with fewer beds now in the care system.
3. Intermediate Care
4. Intermediate care options are increasingly available in a community setting with reduced reliance on traditional hospital based approaches. Over the course of the current Strategic Commissioning plan, there will be a concerted effort to move both the care modality from one of ‘traditional care’ to re-ablement and promoting independence as well as the location of care to increasing care options in peoples’ own homes or homely settings.
5. Long Term Conditions

Through increased opportunities presented by technology, telehealth, and people looking to self care etc, then so there will be a requirement for care to shift accordingly. As well as creating additional capacity to cope with additional demand, this should also improve preventative approaches to care and an associated reduction in unplanned hospital admissions.

21. What efficiency savings do you plan to deliver in 2016-17?

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Care and Housing Services</td>
<td>£4.880m</td>
</tr>
<tr>
<td>Health Services</td>
<td>£5.677m</td>
</tr>
</tbody>
</table>
22. Do you anticipate any further delegation of functions to the integration authority? (If so, please provide details of which services and anticipated timescales)

No

Scottish Borders Health and Social Care Partnership
Budget Scrutiny: Integration Authorities

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.

23. Which integration authority are you responding on behalf of?
Scottish Borders Health and Social Care Partnership

24. 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>92.619</td>
</tr>
<tr>
<td>Local authority*</td>
<td>46.531</td>
</tr>
<tr>
<td>Set aside budget</td>
<td>18.128</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>157.278</strong></td>
</tr>
</tbody>
</table>

*£5.267m of Social Care Funding Allocation from the Scottish Government (the “£250m”), for the purposes of reporting, is shown within the health board budget

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

This is the budget delegated to the Health and Social Care Partnership 16/17:

<table>
<thead>
<tr>
<th></th>
<th>2015-16 £m</th>
<th>2016-17 £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare</td>
<td>88.706</td>
<td>92.619</td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community healthcare</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
26. 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.

£5.267m of social care funding was allocated to the Scottish Borders Partnership. At the time of reporting, the direction of resources to meet the following commitments has been approved by the board:

1. Make progress on charging thresholds for all non-residential services

   2016/17 cost = £0.154m
   2017/18 cost = £0.154m

2. Expand capacity to accommodate growth in demand for services as a consequence of demographic change

   2016/17 cost = £1.081m
   2017/18 cost = £1.081m

3. Deliver the Living Wage for all social care workers with an implementation date of 1 October

   2016/17 cost = £0.813m
   2017/18 cost = £1.626m

In addition, a one-off contribution was made to the Alcohol and Drug Partnership of £220k, in order to preserve service levels for one-year in light of the Scottish Government grant allocation reduction and enable a transition plan to be developed.

For 2016/17, £2.048m of the allocation has been directed to date in relation to the above commitments. For 2017/18 and beyond, this increases to £2.861m, when the full-year impact of the implementation of a living wage of £8.25 from 1st October will be experienced.

This therefore leaves £2.999m and £2.406m uncommitted for 2016/17 and future years respectively, although the board is now developing and considering further directions for this resource to fund the implementation of new models of health and social care in the Scottish Borders and significant pressures across the partnership.

It is expected that the total allocation will be spent in 2016/17.
Budget setting process

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

1. The 2016/17 budget for the partnership (the resources delegated to it by its partners) is the outcome of respective financial planning processes within the health board and the local authority and does not necessarily fully reflect the priorities reflected within the partnership’s strategic and commissioning and implementation plans which were only approved late in the preceding financial year.

2. Agreeing the 2016/17 partnership delegated budget prior to the 1st April was particularly challenging due to a number of factors:
   - Respective financial planning timetables within partner organisations
   - A lack of certainty over funding levels to partners (core funding and ringfenced allocations) at this time (in particular health board funding)
   - Unprecedented levels of efficiency savings requiring planning and delivery in order to ensure overall affordability of the integrated budget (presently there is a budget ‘gap’ of £793k and total efficiency / savings requirements of £7.393m

3. A lack of agreement across key stakeholders of how social care funding allocation should be reflected within the budget delegated to the partnership and its intended use.

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

1. A more integrated and cohesive financial planning process will be established for 2017/18 and beyond which will more clearly enable planned investment and disinvestment decisions to be based on the partnership’s strategic priorities and local objectives.

2. A more integrated and cohesive financial planning process will enable a more co-ordinated, prioritised and singular approach to the planning and delivery of investment priorities and savings targets/disinvestment.

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

The financial statement / integrated budget was approved at an extra-ordinary meeting of the Integration Joint Board on the 30th March 2016.

30. When would you anticipate finalising your budget for 2017-18?
It is anticipated that the 2017/18 budget will be finalised and approved by the board during March 2017. The status of this budget however, whether it be provisional or final, will wholly depend on the status of funding settlements between partners and the Scottish Government at that time.

Integration outcomes

31. 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:

There are a number of planned intentions that will result in the shift of resource over the medium-term. Three examples however are:

- Implementation of a localities based model for the provision of health and social care through a single point of contact
- A greater shift to early intervention and preventative services, including enablement and promotion and support of independence
- Improved support for carers and people with long-term conditions

32. What efficiency savings do you plan to deliver in 2016-17?

The budgets delegated to the partnership are predicated on the requirement to deliver £7.393m of efficiency and other savings during 2016/17. NHS Borders and Scottish Borders Council therefore require to deliver £4.710m and £2.663m respectively.

<table>
<thead>
<tr>
<th>NHS Borders Savings</th>
<th>2016/17 £'000</th>
<th>2016/17 £'000</th>
<th>2016/17 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>recurring</td>
<td>n/recurring</td>
<td>total</td>
</tr>
<tr>
<td>Nursing Skill Mix Review</td>
<td>(93)</td>
<td>0</td>
<td>(93)</td>
</tr>
<tr>
<td>Non Support Service Admin</td>
<td>(118)</td>
<td>0</td>
<td>(118)</td>
</tr>
<tr>
<td>Supplies Uplift 2016/17</td>
<td>(235)</td>
<td>0</td>
<td>(235)</td>
</tr>
<tr>
<td>Travel Costs</td>
<td>0</td>
<td>(95)</td>
<td>(95)</td>
</tr>
<tr>
<td>Suspend Clinical Excellence Fund 2016/17</td>
<td>0</td>
<td>(186)</td>
<td>(186)</td>
</tr>
<tr>
<td>Clinical Productivity</td>
<td>(750)</td>
<td>0</td>
<td>(750)</td>
</tr>
<tr>
<td>Borders Wide Day Hospitals Review</td>
<td>(200)</td>
<td>0</td>
<td>(200)</td>
</tr>
<tr>
<td>Drugs &amp; Prescribing</td>
<td>(600)</td>
<td>0</td>
<td>(600)</td>
</tr>
<tr>
<td>Review Step Down Facilities</td>
<td>(200)</td>
<td>(350)</td>
<td>(550)</td>
</tr>
<tr>
<td>Improving Pathway of Care</td>
<td>(640)</td>
<td>0</td>
<td>(640)</td>
</tr>
<tr>
<td>MH &amp; LD Management Costs</td>
<td>(100)</td>
<td>0</td>
<td>(100)</td>
</tr>
<tr>
<td>AHP Models of Care</td>
<td>(100)</td>
<td>0</td>
<td>(100)</td>
</tr>
<tr>
<td>Review Public Health</td>
<td>0</td>
<td>(150)</td>
<td>(150)</td>
</tr>
<tr>
<td>Other Schemes</td>
<td>(100)</td>
<td>0</td>
<td>(100)</td>
</tr>
<tr>
<td><strong>Total Savings Proposed</strong></td>
<td><strong>(3,136)</strong></td>
<td><strong>(781)</strong></td>
<td><strong>(3,917)</strong></td>
</tr>
<tr>
<td><strong>Required Savings</strong></td>
<td><strong>3,261</strong></td>
<td><strong>979</strong></td>
<td><strong>4,239</strong></td>
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</tbody>
</table>
### Scottish Borders Council Savings

<table>
<thead>
<tr>
<th>Description</th>
<th>2016/17</th>
<th>2016/17</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td></td>
<td>recurring</td>
<td>n/recurring</td>
<td>total</td>
</tr>
<tr>
<td>Supporting Independence when providing Care at Home</td>
<td>(316)</td>
<td>0</td>
<td>(316)</td>
</tr>
<tr>
<td>Further contribution of surplus from SB Cares</td>
<td>(547)</td>
<td>0</td>
<td>(547)</td>
</tr>
<tr>
<td>Reduction in the costs of Commissioning</td>
<td>(378)</td>
<td>0</td>
<td>(378)</td>
</tr>
<tr>
<td>Residential and Home Care Efficiencies and Income</td>
<td>(235)</td>
<td>0</td>
<td>(235)</td>
</tr>
<tr>
<td>Assessment and Care Management</td>
<td>(100)</td>
<td>0</td>
<td>(100)</td>
</tr>
<tr>
<td>Staffing</td>
<td>(300)</td>
<td>0</td>
<td>(300)</td>
</tr>
<tr>
<td>Adults with Learning Disabilities Efficiencies</td>
<td>(549)</td>
<td>0</td>
<td>(549)</td>
</tr>
<tr>
<td>Older People Efficiencies</td>
<td>(234)</td>
<td>0</td>
<td>(234)</td>
</tr>
<tr>
<td>Other</td>
<td>(4)</td>
<td>0</td>
<td>(4)</td>
</tr>
<tr>
<td></td>
<td>(2,663)</td>
<td>0</td>
<td>(2,663)</td>
</tr>
</tbody>
</table>

33. Do you anticipate any further delegation of functions to the integration authority? (If so, please provide details of which services and anticipated timescales)

During 2016/17, it is not anticipated that further functions will be delegated to the Partnership. As it evolves however, further delegation in future financial years is not discounted.
The Highland Partnership

Budget Scrutiny: Integration Authorities

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.

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

The Highland Partnership

35. 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>489.672</td>
</tr>
<tr>
<td>Local authority</td>
<td>91.600</td>
</tr>
<tr>
<td>Set aside budget</td>
<td>N/A*</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>581.272</td>
</tr>
</tbody>
</table>

* No set aside budget (all budgets included in the partnership)

36. 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>367.819</td>
<td>365.115</td>
</tr>
<tr>
<td>Community healthcare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family health services &amp; prescribing</td>
<td>101.516</td>
<td>100.183</td>
</tr>
<tr>
<td>Social care</td>
<td>111.540</td>
<td>115.974</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>580.875</td>
<td>581.272</td>
</tr>
</tbody>
</table>

In order to breakeven, in 2016/17, savings of £22.4m need to be achieved.

37. 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.

Amount allocated £10.7m, planned utilisation as follows:

- £3.2m Living Wage
- £2.6m Full year effect of existing packages
- £1.2m Care Home contracts uplift
• £2.7m Highland Council net reduction in core budget funding to offset wider budget pressures
• £1.5m Pay / National Insurance increases
• £0.5m Other
• (£1.0m) Shortfall on the above – to be met from efficiencies

Budget setting process

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

The change in Local Authority settlement led to a re-negotiation of the previously agreed funding provided by the Highland Council. As a result of this, the Council’s funding reduced and this was covered from part of the £250m as set out above. This partly reflected the fact that the guidance for the £250m reflected the IJB model rather than the Lead Agency model. The guidance appeared to allow for some financial benefit to accrue to the Local Authority from the £250m. The Council’s reduction in funding to the Partnership was the mechanism by which this was handled in the Lead Agency model.

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

Weekly informal chief officer meeting attended by THC and NHSH leads.
Review of PIs ensuring THC and NHSH sign up.
ASCG agreed priorities for improvement groups
Engagement with stakeholders including staff, service users, Board & THC
We hope to put in place three-year agreements with Highland Council – however this is always likely to be depend upon the Council’s settlement being as planned (or not materially different).

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

February 2016

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

We would aim for February 2017 at the latest, but this will very much depend on the timing of the next Spending Review.

Integration outcomes

42. 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:

As we have now been integrated for 4 years, we have seen a shift in resource from institutional based care – hospital and care homes to home based care which we would expect to continue. We have also lost the artificial divide of
budgets within integrated community teams enabling recruitment of the right skills to keep people safe and well at home. Finally, we are exploring alternative housing models to meet demands in the future again reducing the reliance on institutional care.

43. What efficiency savings do you plan to deliver in 2016-17?

As set out under Q3, savings of £22.4m need to be delivered in the Highland Partnership in 2016/17. Generally speaking, these will be delivered across the health and social care economy (as noted above it is increasingly difficult to differentiate between health and social care budgets).

44. Do you anticipate any further delegation of functions to the integration authority? (If so, please provide details of which services and anticipated timescales)

All Adult Social care was devolved to NHS Highland in 2012 and there are no plans to devolve any other functions currently.

All community Child Health functions were devolved to the Highland Council in 2012 and there are currently no plans to devolve any other functions.

Whilst we have tried to answer the questions to reflect the current position it is worth highlighting that Highland operates under the Lead Agency model, and this is now in its 5th year. Therefore many of the questions, that reflect the new IJBs that have been established from 1 April 2016, do not have a direct bearing on the situation in Highland.
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’.

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, 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 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:

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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
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, %](image)

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

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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:

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.”
APPENDIX: IJB BUDGET SURVEY

Budget Scrutiny: Integration Authorities

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>
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</thead>
<tbody>
<tr>
<td>Health board</td>
<td></td>
</tr>
<tr>
<td>Local authority</td>
<td></td>
</tr>
<tr>
<td>Set aside budget</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
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</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>
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</thead>
<tbody>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community healthcare</td>
<td></td>
<td></td>
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<tr>
<td>Family health services &amp; prescribing</td>
<td></td>
<td></td>
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<tr>
<td>Social care</td>
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<tr>
<td><strong>Total</strong></td>
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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>
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<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>
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<td>People who use health and social care services have positive experiences of those services, and have their dignity respected.</td>
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<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>
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<td>Health and social care services contribute to reducing health inequalities.</td>
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<td></td>
</tr>
<tr>
<td>National Outcome</td>
<td>Indicators</td>
<td>2016-17 budget</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
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<td>People who provide unpaid care are supported to look after their own health and</td>
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<tr>
<td>wellbeing, including to reduce any negative impact of their caring role on their</td>
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<tr>
<td>own health and wellbeing.</td>
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<td>People who use health and social care services are safe from harm.</td>
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<td>People who work in health and social care services feel engaged with the work</td>
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<td>they do and are supported to continuously improve the information, support,</td>
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<td>care and treatment they provide.</td>
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<tr>
<td>Resources are used effectively and efficiently in the provision of health and</td>
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<td></td>
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<tr>
<td>social care services.</td>
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<td></td>
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