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?**

   Argyll and Bute

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>200.448</td>
</tr>
<tr>
<td>Local authority</td>
<td>55.553</td>
</tr>
<tr>
<td>Set aside budget</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>256.001</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</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>105.000</td>
<td>106.000</td>
</tr>
<tr>
<td>Community healthcare</td>
<td>43.851</td>
<td>44.650</td>
</tr>
<tr>
<td>Family healthcare &amp; prescribing</td>
<td>44.469</td>
<td>45.218</td>
</tr>
<tr>
<td>Social care</td>
<td>56.543</td>
<td>60.133</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>249.863</strong></td>
<td><strong>256.001</strong></td>
</tr>
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</table>

Savings totalling £8.498m have been approved for 2016-17 to deliver a balanced integrated budget.

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.**

   The amount allocated to Argyll and Bute IJB was £4.580m. The additional funding has been allocated to fund the below:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment of Living Wage to Social Care staff</td>
<td>1.300</td>
</tr>
<tr>
<td>Increase in income thresholds applied for non-residential care</td>
<td>0.125</td>
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<tr>
<td>Demand pressure - increase in older people services</td>
<td>0.573</td>
</tr>
<tr>
<td>Demand pressure - services for learning disabled due to carer breakdown.</td>
<td>0.200</td>
</tr>
<tr>
<td>Demand pressure - young people due to extended entitlement to care and support as a result of CYPA</td>
<td>0.115</td>
</tr>
</tbody>
</table>
Budget setting process

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

There were particular challenges in relation to the different timeframes for budget setting within the Council and Health Board and the timeframe available to the IJB to approve a budget following confirmation of financial settlements from both partners. Alongside this the announcement of the £250m of additional funding, together with some confusion over its use added to the challenges of setting a budget for 2016-17.

The due diligence process following the 2015-16 year-end highlighted an additional budget gap. The IJB has been in a position of having to identify savings options within an accelerated timescale, these are going to be very difficult to deliver and secure during 2016-17.

The integrated budget forecast budget gap for 2016-17 is £8.5m. This is a difficult position to plan to address, particularly for a new organisation. Ideally we would have liked to be in a position to approve a 3 year budget from 2016-17 onwards in line with the delivery of the Strategic Plan but this was not possible due to the one year offers of funding from Council and Health partners and the desire to have changes to service delivery being driven by Locality Planning Groups, which were not fully up and running in time to deliver this.

The IJB has approved a Quality and Financial Plan for 2016-17 with savings of £8.5m to deliver a balanced budget.

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?

The IJB and Strategic Management Team are aware of the requirements to start planning for subsequent years at the earliest opportunity to allow for an appropriate period of consultation and engagement with communities and service users. This is also to ensure the deliverability of the savings required, which will total an estimated £20.7m across the 3 years of the Strategic Plan.

An approach to the budget setting process for 2017-18 and 2018-19, the remaining period of the Strategic Plan, will be presented to the IJB in
September 2016. Early engagement with Locality Planning Groups will be key to this to ensure that quality of care and the needs of the communities is at the heart of any service re-design.

Regular development sessions with IJB members to provide further information to members and to get valuable input from them will be part of the development process for the Quality and Financial Plan. This will also require closer working and communication with the partners to ensure plans can be supported and delivered.

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

Approved by IJB on 22 June 2016

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

By March 2017

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:

Three examples are:

1. Continued reduction in delayed discharges, acute bed numbers due to reduced length of stay and occupancy and reduced A&E attendance for at risk patients (co-morbidity, frail elderly etc). Disinvesting nursing and infrastructure resource, to commission carer support and care responder services, increase in community nursing teams and Technology enabled Care.

2. Reduction in care home beds as they will be used for people who require a higher level of care and consequently a shorter length of stay. We will disinvest this resource to support care home providers capability to deliver the higher level of care and develop in partnership with our Third sector colleagues a menu of care and health services supporting well being, including for example Community Support Hub, re-ablement services, befriending.

3. Primary care and traditional community services are under pressure as evidenced by difficulties in recruitment and retention to rural GP posts, turnover, increasing locum costs and demographic trends in our workforce. Through the new GMS contract, the HSCP plans to sustain the workforce by merging/federating practices to drive out efficiency in back office services. Utilising digital services for online appointing and self triage via use of the modernising primary care initiatives.

We will use the resources available to us to invest in strengthening the support and making best use of the capacity and capability of our Primary/community health care teams by:
• Improving pre hospital care including support to GPs e.g. formal remote decision support by consultant (NHS GG&C) to prevent referral or exacerbation of patient conditions
• Redesigning and reshaping out of hours services
• Shifting care from an unplanned to planned basis
• Reducing the burden and patient risk around polypharmacy and medication errors by investing in pharmacy support
• Blurring the lines and resource between Rural General and community hospital and primary care and social care pathways reducing handoffs with focus on a person centred care efficient pathway

Thus supporting better management of older people and chronic disease in the community.

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

There is a Quality and Financial Plan agreed for 2016-17 which includes savings totalling £8.498m. Services will be redesigned, provided in a different way, possibly in a different setting by a different provider. The delivery of the Quality and Financial Plan is in line with the Strategic Plan and the longer term vision for the delivery of services, some savings capitalise on the economies of scale of integration with the removal of waste and duplication.

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

No. All adult, children and families and criminal justice social work services are delegated to the IJB, along with all health services, including acute hospital and commissioned services from NHS GG&C.
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. **The indicators noted below are in addition to the 23 prescribed sub-indicators.**

(b) If possible, also show how your budget links to these outcomes. **Not possible to provide this.**

<table>
<thead>
<tr>
<th>National Outcome</th>
<th>Indicators</th>
<th>2016-17 budget</th>
</tr>
</thead>
</table>
| People are able to look after and improve their own health and wellbeing and live in good health for longer. | • % of Older People receiving Care in the Community  
• Number of people waiting more than 12 weeks for homecare service  
• % of Learning Disability service users with a Person Centred Plan  
• % Looked After and Accommodated Children in family placements (kinship and foster care)  
• Number of external placements for Looked After and Accommodated Children  
• Number of Alcohol Brief Interventions in line with SIGN 74 guidelines  
• Proportion of new-born babies exclusively breast fed at 6-8 Weeks  
• Number of ongoing waits >4 weeks for the 8 Key Diagnostic Tests  
• Number of <18s with type 1 diabetes with an Insulin Pump  
• Number of >18s with type 1 diabetes with an Insulin Pump  
• % of MMR1 immunisation uptake rates at 5 years old | |
<table>
<thead>
<tr>
<th>National Outcome</th>
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<th>2016-17 budget</th>
</tr>
</thead>
</table>
| 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. | • Number of Delayed Discharge Clients from Argyll and Bute  
  • Number of Enhanced Telecare Packages  
  • Number of people 65+ receiving homecare  
  • <=3 weeks wait between substance misuse referral and first treatment  
  • % of patients who wait no longer than 18 weeks for referral to treatment from Child and Adolescent Mental Health Services (CAMHS)  
  • % of patients who wait no longer than 18 weeks for psychological therapies  
  • % of Mental Health clients receiving care in the community  
  • % of patients waiting no longer than 4 hours in A&E |                |
| People who use health and social care services have positive experiences of those services, and have their dignity respected. | • Number of abbreviated customer service questionnaires sent to Adult Care Service Users  
  • Reduction in bed days for long term conditions  
  • Number of patients with early diagnosis and management of dementia  
  • % patients admitted to a stroke unit on day of admission/next day |                |
<table>
<thead>
<tr>
<th>National Outcome</th>
<th>Indicators</th>
<th>2016-17 budget</th>
</tr>
</thead>
</table>
| Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. | • Average working days between referral and initial Adult Protection case conference  
• % of Learning Disability service users with a Person Centred Plan  
• % of Looked After and Accommodated Children with over one year in care with a plan for permanence recorded  
• % of care leavers with a pathway plan  
• Number of outpatients ongoing waits >12 weeks  
• % of outpatients on the waiting list with social unavailability  
• % of outpatients on the waiting list with medical unavailability  
• % of patients on the admissions waiting list with social unavailability  
• % of patients on the admissions waiting list with medical unavailability |               |
| Health and social care services contribute to reducing health inequalities. | • Number of Delayed Discharge Clients from Argyll and Bute  
• <=3 weeks wait between substance misuse referral and first treatment  
• % of Mental Health clients receiving care in the community  
• Number of treatment time guarantee completed waits >12 weeks  
• Number of treatment time guarantee ongoing waits >12 weeks |               |
<table>
<thead>
<tr>
<th>National Outcome</th>
<th>Indicators</th>
<th>2016-17 budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who provide unpaid care are supported to look after their own health and</td>
<td>• % of Carers who feel supported to continue in their caring role</td>
<td></td>
</tr>
<tr>
<td>wellbeing, including to reduce any negative impact of their caring role on their</td>
<td></td>
<td></td>
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<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>• % of Adult Care service users reporting they feel safe at assessment</td>
<td></td>
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<tr>
<td></td>
<td>• % of Child Protection investigations with Initial Referral Tripartite Discussion within 24 hours</td>
<td></td>
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<tr>
<td></td>
<td>• % of Children on Child Protection Register with a current risk assessment</td>
<td></td>
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<tr>
<td></td>
<td>• % of Children on Child Protection Register with no change of Social Worker</td>
<td></td>
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<tr>
<td></td>
<td>• % of Children on Child Protection Register with a completed Child Protection Plan</td>
<td></td>
</tr>
<tr>
<td>People who work in health and social care services feel engaged with the work</td>
<td>• % of staff Performance Review and Developments completed</td>
<td></td>
</tr>
<tr>
<td>they do and are supported to continuously improve the information, support, care</td>
<td>• Average full time equivalent days lost due to sickness absence</td>
<td></td>
</tr>
<tr>
<td>and treatment they provide.</td>
<td>• % of staff with KSF and Personal Development Plan completed</td>
<td></td>
</tr>
<tr>
<td>National Outcome</td>
<td>Indicators</td>
<td>2016-17 budget</td>
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<tr>
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</tbody>
</table>
| Resources are used effectively and efficiently in the provision of health and social care services. | • % of Scottish Children’s Reporters Administration reports submitted on time  
• Average hours per week taken to complete Community Payback Order Unpaid Work/Community Service Orders  
• % Criminal Justice Social Work Reports submitted to Court on time  
• % Community Payback Order cases seen without delay, within 5 days  
• Service Medical Record return rate  
• % of Surgical same day admissions  
• % of new outpatient appointments Did Not Attend rates  
• % pre-operative stays | |
Delayed Discharges

In relation to delayed discharge the Committee is interested in three areas. The extent to which the IJB is able to direct spending, how much money is available to tackle delayed discharge and how well it is being spent to eradicate the problem.

1. **As an Integrated Authority what responsibility do you have for tackling the issue of delayed discharges?**

The Argyll and Bute HSCP has responsibility for the delivery of all health and social care services across the area. We work closely with NHS Highland and Greater Glasgow and Clyde to ensure people return home with an appropriate level of care to meet their stated outcomes.

2. **What responsibility do you have for allocating expenditure including additional sums allocated by the Scottish Government to tackle delayed discharges?**

Full responsibility.

3. **How much was spent in 2015-16 on tackling delayed discharges? If necessary this answer can be based on your shadow budget for 2015-16.**

£361k directly used to tackle delayed discharges during 2015-16. This does not include the additional hospital costs as a result of delayed discharges.

4. **What is the total funding (in 2016-17) you are directing to address the issue of delayed discharges? Please provide a breakdown of how much money has been received from each of the following for this purpose:**

   a. NHS board £552k
   b. Local authority £270k
   c. Other (please specify)

The total of £822k includes budget allocated to tackle delayed discharges and does not include the full actual hospital costs of the delayed discharges.

5. **How was the additional funding allocated by the Scottish Government to tackle delayed discharges spent in 2015-16? How will the additional funding be spent in the current and next financial years?**

The HSCP have directed money to a number of initiatives including an in reach team to identify and move on quickly those patients delayed in Glasgow hospitals. This has had a positive impact on the number of people delayed in various Glasgow Hospitals. We have also directed monies at overnight care teams to ensure people are supported to stay at home. We have also invested in opening up access to our assessment framework to health staff to ensure people are not delayed in hospital waiting for an assessment. Decisions for future years will be entirely based around improving assessment activity and developing our approach to re-ablement to ensure older people have an opportunity to increase their independent living skills and reduce the need for treatment and stays in hospital.
6. What impacts has the additional money had on reducing delayed discharges in your area?

The money has acted as a lever for change. This has allowed us to invest in services to ensure we develop our model of care. We still have more to do in terms of reaching the 72 hour target set by Scottish Government but are looking for further ways to prevent hospital admission and maintain people at home for longer.

7. What do you identify as the main causes of delayed discharges in your area?

The completion of assessment and availability of care at home in some of our more rural settings.

8. What do you identify as the main barriers to tackling delayed discharges in your area?

Availability of care at home staff.

9. How will these barriers to delayed discharges be tackled by you?

We are working with key stakeholders to develop our model of care. We are widening the group of staff who can complete universal assessments and we are developing SDS options to enhance the options available to individuals and families relating to how care and support is delivered. For example, we are working with one community to develop a social enterprise model using SDS.

10. Does your area use interim care facilities for patients deemed ready for discharge?

We have used care home beds when appropriate to provide step down beds as part of a care plan.

11. If you answered yes to question 10, of those discharged from acute services to an interim care facility what is their average length of stay in an interim care facility?

6/8 weeks for re-ablement.

12. Some categories of delayed discharges are not captured by the integration indicator for delayed discharges as they are classed as ‘complex’ reflecting the fact that there are legal processes which are either causing the delay (e.g. application for guardianship orders) or where there are no suitable facilities available in the NHS board area. Please provide the total cost for code 9 delayed discharges for 2015-16? What is your estimate of cost in this area in the current and next financial years?

Based on the activity data available for Argyll and Bute hospitals the cost of code 9 delayed discharges for 2015-16 was £1.877m. This only includes costs for hospitals in the Argyll and Bute area and doesn’t include the cost of any patients in NHS GG&C hospitals, this activity data is not available at this time.
Social and Community Care Workforce

In relation to the social and community care workforce the Committee is interested in the recruitment of suitable staff including commissioning from private providers and the quality of care provided.

1. **As an Integrated Joint Board what are your responsibilities to ensure there are adequate levels of social and community care staff working with older people?**

   The Integration Joint Board is responsible for ensuring that there is capacity to provide the services required, this will include increasing or changing capacity to facilitate the shift in the balance of care.

   The IJB has identified 6 areas of focus to support the achievement of the national outcomes, this clearly articulated what this means for our workforce and the strategic plan outlines that the workforce needs to change and transform to refocus on anticipatory care and prevention. The IJB requires the workforce to be motivated, committed, skilled and valued, working to maximum capability and capacity. Over the 3 year period of the Strategic Plan a workforce plan will be put in place which will work towards operating with single integrated teams, reduce the burden of work by removing waste, duplication and implementing standard operating procedures to free up staff time and resource and implementing workforce development and training programmes.

2. **Are there adequate levels of these social and community care staff in your area to ensure the Scottish Government’s vision of a shift from hospital based care to community based care for older people is achieved? If not, please indicate in what areas a shortage exists.**

   The recruitment and retention of care staff is a nationally recognised problem. Although this is affecting care provision in a number of our urban localities, it is a particularly acute issue for rural and remote locations. There are only two areas within Argyll and Bute where there are not currently problems with the level of care staff availability, these are Helensburgh and Rothesay.

3. **Other than social and community care workforce levels, are there other barriers to moving to a more community based care?**

   The body corporate model is presenting significant challenges to the partnership and trade unions in addressing terms and conditions issues and differences in policies between the two employers, including redundancy, revising job descriptions and supporting single team working for service delivery. This is causing delays in job re-design and recruitment, perpetuating inefficient working and different organisational cultures and increasing staff uncertainty and anxiety which impacts on morale and performance.

   The development of new models of care will require wider involvement from communities through Locality Planning Groups. The Third and Independent
sectors will be key partners in delivering the capacity for change and there has to be recognition of the value that these sectors can bring to community based care.

The pace and scale of change bring challenges in terms of deliverability, making significant changes to services across the whole area at the same time is going to be a real challenge.

Argyll and Bute covers a wide geographical area with a number of remote and rural communities, it will be a challenge to ensure that there is capacity for services in these areas and that each area has a tailored approach depending on care need requirements.

4. What are the main barriers to recruitment and retention of social and community care staff working with older people in your area?

Unemployment rates in Argyll and Bute are below the national average. The economy of the area is predominantly service based with over 85% of the jobs in the area being provided within the service sector, these are the jobs in the area that care providers have to compete with to employ staff.

The support to the independent sector to uplift care staff to the Living Wage from 1 October 2016 may make a role in the caring profession more attractive.

There is a Social Work Training Board in place within the Council which supports the development of the social work workforce, with employees being supported to study to degree level to ensure we can develop a competent, confident, skilled and qualified social care workforce capable of meeting the current and future service demands.

5. What mechanisms (in the commissioning process) are in place to ensure that plans for the living wage and career development for social care staff, are being progressed to ensure parity for those employed across local authority, independent and voluntary sectors?

There are ongoing discussions between providers, finance and commissioning staff representing the IJB. Cost rate uplifts are being calculated for each provider individually taking individual provider circumstances into account. The majority of the uplift assessments are now completed and the IJB expect to be able to notify providers to ensure compliance by 1 October 2016. Any future commissioning processes will be carried out using a collaborative approach to ensure parity across service contracts in line with Fair Work Practices. This will allow us to meet our obligation to pay the national minimum wage from 1st April and the Scottish Living Wage from 1st October. In addition to this we expect suppliers to meet the guidance in respect of support for learning and development.

6. What proportion of the care for older people is provided by externally contracted social and community care staff?
70.3% of homecare for older people is provided by externally contracted providers.

7. **How are contracts monitored by you to ensure quality of care and compliance with other terms including remuneration?**

The Procurement and Commissioning Team, in partnership with the service departments, contract manages all externally commissioned services within Argyll and Bute on a quarterly basis. This process includes monitoring Care Inspectorate information, managing service user and carer feedback, undertaking quality of care monitoring, benchmarking provider performance and costs and addressing issues of non-compliance. The contract management process has worked well leading to prompt action and improvements where there have been concerns about service providers.

Links are in place to ensure prompt payment is made for services delivered. This is monitored jointly by procurement and commissioning and finance through the Carefirst system and contract values. In addition, links with other internal services like Health and Safety are established and they monitor operational risk assessments completed by suppliers on an annual basis.