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?**

   Falkirk Integration Joint Board

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

<table>
<thead>
<tr>
<th>Falkirk IJB</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health board</td>
<td>106.444</td>
</tr>
<tr>
<td>Local authority</td>
<td>61.466</td>
</tr>
<tr>
<td>Set aside budget</td>
<td>24.155</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>192.065</strong></td>
</tr>
</tbody>
</table>

   Note: excludes £8.013m of Partnership Funding flowing through NHS Board included in IJB initial budget total of £200.078m.

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>£m</th>
<th>2015-16</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>24.675</td>
<td>24.155</td>
</tr>
<tr>
<td>Community healthcare</td>
<td>40.253</td>
<td>39.725</td>
</tr>
<tr>
<td>Family health services &amp; prescribing</td>
<td>68.443</td>
<td>66.719</td>
</tr>
<tr>
<td>Social care</td>
<td>59.409</td>
<td>61.466</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>192.780</strong></td>
<td><strong>192.065</strong></td>
</tr>
</tbody>
</table>

   Note: 2016/17 Social Care budget includes £4.540m of funding from Integration Fund (the £250m budget allocated for social care). On a like for like basis the total 2016/17 budget would equate to £187.525m.

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.**

   An update on the use of these funds is contained within the IJB Financial Report and Budget Recovery Plan update presented to the IJB on 5 August 2016.
5. Please describe any particular challenges you faced in agreeing your budget for 2016-17

The process detailed within the Falkirk Health and Social Care Partnership Integration Scheme and a comprehensive, transparent and collegiate due diligence process assisted greatly with 2016/17 budget setting. Although there remain matters to address going forward this provided a solid foundation for agreeing initial budgets.

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 Falkirk Health and Social Care Partnership Integration Scheme Integration Scheme details the process to be used.

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

The IJB budget was set at the IJB meeting of 24 March 2016.

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

The Integration Scheme details the process to be used and interface with Local Authority and NHS Board budget setting. However the finalisation of the budget is largely dependent on the timing of financial settlements to Local Authorities and NHS Boards so it is difficult to be definitive at this point in time. The treatment of the Integration Fund within the 17/18 Scottish budget will be particularly important for IJBs given the significant cost of implementing the living wage.

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 partnership would intend to align future expenditure with the Strategic Plan and the local outcomes detailed and the evidence contained within the Joint Strategic Needs Assessment. As part of the local delivery plan being developed to implement the Strategic Plan detailed financial planning will be required.

This process has already begun with a review of projects and services supported by Partnership Funding streams. The outcome of this Partnership Funding review was presented to the IJB on 3 June 2016 meeting.

10. What efficiency savings do you plan to deliver in 2016-17?
These are as detailed in the budget setting papers which were presented to the IJB meeting on 24 March 2016.

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

Further delegation of functions is not anticipated in the short term but will be kept under review.
Performance framework

12. (a) Please provide details of the indicators that you will use to monitor performance and show how these link to the nine national outcomes
(b) If possible, also show how your budget links to these outcomes

<table>
<thead>
<tr>
<th>National Outcome</th>
<th>Indicators</th>
<th>2016-17 budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>People are able to look after and improve their own health and wellbeing and live in good health for longer</td>
<td>% of adults able to look after their own health very well or quite well</td>
<td></td>
</tr>
</tbody>
</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. | % adults supported at home who agree that they are supported to live as independently as possible  
% of people admitted from home to hospital during the year, who are discharged to a care home  
Proportion of last 6 months of life spent at home or in community setting.  
% of adults age 65+ with intensive needs (10+ hrs) receiving care at home |                |
| People who use health and social care services have positive experiences of those services, and have their dignity respected. | % of adults supported at home who agree that they had a say in how their help, care or support was provided.  
% of adults supported at home who agree that their health and care services seemed to be well co-ordinated.  
% of adults receiving any care or support who rate it as excellent or good  
% of people with positive experience of care at their GP practice.  
Expenditure on end of life care |                |
| Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. | % of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life  
Rate of emergency admissions for adults |                |
<table>
<thead>
<tr>
<th>National Outcome</th>
<th>Indicators</th>
<th>2016-17 budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and social care services contribute to reducing health inequalities</td>
<td>▪ Proportion of care services graded ‘good’ or better in Care Inspectorate Inspections</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Premature mortality rate</td>
<td></td>
</tr>
<tr>
<td>People who provide unpaid care are supported to look after their own health</td>
<td>▪ % of carers who feel supported to continue in their caring role.</td>
<td></td>
</tr>
<tr>
<td>and wellbeing, including to reduce any negative impact of their caring role on</td>
<td></td>
<td></td>
</tr>
<tr>
<td>their own health and wellbeing</td>
<td>% of adults supported at home who agree they felt safe</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Emergency (all) bed day rate per 1,000 population</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Readmissions to hospital within 28 days of discharge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Falls – rate per 1000 patients 65+</td>
<td></td>
</tr>
<tr>
<td>People who use health and social care services are safe from harm.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of adults supported at home who agree they felt safe</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Emergency (all) bed day rate per 1,000 population</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Readmissions to hospital within 28 days of discharge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Falls – rate per 1000 patients 65+</td>
<td></td>
</tr>
<tr>
<td>People who work in health and social care services feel engaged with the work</td>
<td>% of NHS staff who say they would recommend their workplace as a good place to work</td>
<td></td>
</tr>
<tr>
<td>they do and are supported to continuously improve the information, support,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>care and treatment they provide.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resources are used effectively and efficiently in the provision of health and</td>
<td>% of adults supported at home who agree that their health and care services seemed to be well co-ordinated</td>
<td></td>
</tr>
<tr>
<td>social care services.</td>
<td>▪ Readmissions to hospital within 28 days of discharge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ % of total health and care spend on hospital stays where the patient was admitted in an emergency</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Older people’s (65+) home care costs</td>
<td></td>
</tr>
<tr>
<td>National Outcome</td>
<td>Indicators</td>
<td>2016-17 budget</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td></td>
<td>(expenditure) per hour.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Bed Days Occupied by Delayed Discharge Patients per 1000 Population aged 75+</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ % of people who are discharged from hospital within 72 hours of being ready</td>
<td></td>
</tr>
</tbody>
</table>
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 Integration Joint Board receives regular reports on Delayed Discharge and this remains an area of priority for the Board.

A Falkirk Delayed Discharge Steering Group is in place to monitor operational performance and find solutions.

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

The relevant expenditure is contained within in-scope functions and the Set Aside budget therefore the responsibility for deploying these resources lies with the IJB.

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.

£0.867m was specifically spent on actions to address delayed discharge. However many other supplementary streams of work, activity and resource are focussed on effective prevention, admission avoidance and supporting rehabilitation and reablement.

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
   b. Local authority
   c. Other (please specify)

Resources which form the payments to the IJB have been allocated in line with the functions detailed within the integration scheme. Some of these functions will contain costs of services aimed at reducing unplanned admission, supporting safe and effective discharge and rehabilitation and reablement which will collectively minimise the incidence of delayed discharge.
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 review of Partnership Funding and investment programme was presented to the June 2016 IJB meeting and is detailed in the Partnership Funding report. It is important to view this investment as an element of a wider programme aimed at delivering the priorities of the Strategic Plan.

Falkirk Partnership’s allocation of the Delayed Discharge Funding for the three years 2015-2018 is £0.864m per annum. In addition, the Scottish Government had provided non-recurring funding to the Falkirk Partnership in 2014/2015 and there was a small carry forward of £33k into 2015/2016 financial year. Therefore, the total available Delayed Discharge resource during 2015/2016 was £0.897m.

The projects funded through the Delayed Discharge resource in 2015/16 were:
- Rapid Response Frailty Clinic
- Discharge Hub & Leaflets
- HELP Packs
- Summerford Reablement
- AHP Support in Summerford
- Contribution towards Ward 5
- Care Home Placements.

Further proposals regarding use of Delayed Discharges funding in 2016/17 were presented to the 5 August IJB meeting within the Chief Officer Report and the Integration Joint Board Financial Report and Budget Recovery Plan Update.

Planned deployment of Delayed Discharge funding in the next financial year will be linked to the development of a strategic whole systems approach including a Frailty Pathway and Discharge to Assess model; anticipatory care planning and short term additional winter capacity across health and social care to support flow through the system.

6. **What impacts has the additional money had on reducing delayed discharges in your area?**

There is ongoing review of Partnership Funded projects. The data published in the ISD annual report 2015/16 shows an 18% decrease on the previous year in bed days occupied by delayed discharge patients in Falkirk compared to the 9% reduction nationally. The investment in the Delayed Discharge projects has supported this reduction in bed days for example, the discharge hub has enabled more focus on discharge process for both standard and complex delays.

7. **What do you identify as the main causes of delayed discharges in your area?**
Availability of care home places for people assessed as requiring a care home remains an issue affecting delayed discharge performance and has been for some significant time. The requirement for interim places and the use of policy on choice continues to be a challenge. Prevention of admission services and discharge to assess services are still in the early stages of development.

There is an increasing number of referrals for care package, both as new referrals (those not previously in receipt of care before their admission to hospital) and those who have been in receipt of care prior to their hospital admission and need their service re-started, sometimes increased. In addition the service also receives referrals for those people who are living at home. Providing these packages of care has been more challenging in recent months against the background of difficulties in recruiting staff to care posts and the increased demand for services as a result of demographic changes.

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

The Integration Joint Board Work receives regular reports on Delayed Discharge Progress. This includes the Delayed Discharge Action Plan which has a focus on addressing four key issues that were impacting on delayed discharge performance. These are:

- There are a number of services which are currently being delivered which are having an impact on small numbers in the population but are not yet having the impact required across the area to reduce ED attendances or acute admissions
- There are patients in hospital whose pathway is delayed for a variety of reasons or if not formally delayed in their discharge, their length of stay in hospital could have been shorter
- There are a number of patients whose discharge becomes delayed as they fall within the scope of the Adults with Incapacity Act
- The right balance and range of care options is not available in Falkirk to support early discharge and avoid admission.

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

The Chief Officer presented a report to the IJB on 5 August 2016. The Board approved a shared vision and aspiration to take a ‘whole system approach’ to address each element of the patient pathway to improve outcomes for people and performance in relation to delays in discharge. The approach will include:

- Development of patient pathways using the Frailty model and Comprehensive Geriatric Assessment (link to current work by Geriatricians and Physicians)
- Home is Best: Introduction of Discharge to Assess Model this will ensure that people are assessed in their own homes immediately on discharge home and tailored packages of care and support are put in place and
reviewed regularly. There is evidence from elsewhere in the UK that this should improve outcomes, reduce delays in discharge and length of stay.

- Review of data on patient flow and bed modelling
- Commissioning to improve flexibility/ review and sustainability
- Standardising and improving assessment and review across the whole system
- Develop a comprehensive Re-ablement model and review intermediate care provision.
- Explore retaining Summerford to develop the Intermediate Care Model in advance of developing a new facility utilising the current I capital commitment.

Many of the building blocks for this ‘whole system’ are in place and are being reviewed as part of the Partnership Funding review and can be realigned to deliver this model.

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

The Partnership has intermediate and short-term assessment beds provided over 3 bases in the area.

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?

The average assessment period is 6 weeks.

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?

Using the direct costs of a community hospital ward and applying this to the Occupied Bed Day’s for Code 9 patients the cost for 2015/16 is estimated at £0.553m. We would, however, suggest that extreme caution should be applied in interpreting this estimate as it does not represent a fully realisable cost should these occupied bed days reduce. Current intelligence suggests a similar level of OBD’s for 2016/17 and therefore a similar level of cost.
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 Integration Joint Board what are your responsibilities to ensure there are adequate levels of social and community care staff working with older people?

This responsibility is addressed through the Strategic Plan, Integrated Workforce Plan and through associated workforce planning and OD activities. This will ensure staff working across all sectors, including the Third and Independent Sectors, have access to and are supported in their personal development suited to the roles and future care delivery. An integrated approach to workforce planning has started will be taken forward to address these areas of responsibility.

There is ongoing work to create employment opportunities. For example the Social Work service has a programme to promote care services as a career option for younger people. This is through the Modern Apprentices (MA’s) programme with placements in our care homes, day centres, MECS and Housing with Care reablement services.

A Joint Staff Forum has been established.

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.

Work is ongoing within the Partnership to develop a full understanding of our workforce demographic and ensure that a resource management model is agreed to support integration.

There remain challenges with recruitment and retention to Care at Home services both within the Council and Independent sectors, which is in line with some other Partnership areas.

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

We have experienced particular challenges with recruitment and retention to posts, funded through for example the Integrated Care Fund, due to the short-term nature of the funding and the wider context for staff moving posts in the current economic climate.

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

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?

The Living Wage commitment sets out plans to improve wages for those working in social care by ensuring that all employees providing direct care and support are being paid the “Living Wage”, an amount of £8.25 per hour from 1 October 2016. The Living Wage is a voluntary rate which employers choose to commit to paying. It goes beyond legal requirements to pay the National Minimum Wage (now called the “National Living Wage”).

Mechanisms are being agreed to see that the living wage commitment covers all purchased services and applies to all hours worked.

The commitment will however not only lead to an increase in the cost of wages for providers but will see them incur other employer costs and the costs associated with maintaining pay differentials. In addition, it is also recognised that providers who operate across England, Wales and Northern Ireland as well as Scotland may have increased costs to maintain equal pay across their organisation.

We are currently confirming the current status of all providers to ascertain where they are at in terms of current pay rates. This will support the work required to ensure available resources to raise wages to the Living Wage are targeted. Meetings and discussions with providers are also active to explore how best we can collaboratively work towards the living wage objective and improve workforce matters.

Our discussions to date tell us that the transparency of the mechanisms adopted will be important if we are to get providers engaged in a positive manner. Undertaking new procurement processes is not a mechanism, at this time, attracting support.

There is also the need to agree the mechanisms for how collaborative agreements (such as the Scotland Excel National Framework Agreement for Care Homes for Adults with Learning Disabilities) will be taken forward.

The mechanisms adopted need to reflect a diversity of circumstance, be affordable in the context of available resources, be transparent and suitably sophisticated to protect existing agreements from the need to undertake new procurements.

6. What proportion of the care for older people is provided by externally contracted social and community care staff?
In terms of home care for older people some 400,000 hours of care are delivered annually by externally contracted social and community care staff. This is approximately a 70% share of the total care delivered.

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

We have a dedicated team embedded within Falkirk Council’s Central Procurement Unit that monitors and manages our social care contracts. The team have in place contract management plans to ensure compliance, to support innovation and where required (e.g National Care Home Contract) complete regular remuneration checks.

In addition to the Central Procurement Unit, within the homecare service there is a Resource Team who regularly review service users whose care is provided by external providers and ensure that the level, quantity and quality of service meets required standards and the individual’s needs.