



The Scottish Parliament
Pàrlamaid na h-Alba

Published 30th November 2016

SP Paper 44

2nd Report, 2016 (Session 5)

Web

Health and Sport Committee

Health and Social Care Integration Budgets



Published in Scotland by the Scottish Parliamentary Corporate Body.

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Health and Sport Committee

Remit: To consider and report on matters falling within the responsibility of the Cabinet Secretary for Health and Sport.



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Introduction

1. The Health and Sport Committee agreed at the start of the Parliamentary session to seek to build an element of budget scrutiny into its work. We agreed to move away from the traditional approach of just considering the Scottish Government's proposals for its budget in the autumn. We have sought to remove the direct link between the Scottish Government's draft budget and our budget scrutiny with a view to influencing the content of the draft budget and the relative priorities given to the health elements. We will be forwarding a copy of our report to the Finance and Constitution Committee to inform its consideration of the Scottish budget.
2. We also identified Health and Social Care Partnerships (HSCPs) as being a key area of scrutiny for its work over the Parliamentary session.
3. We are aware this year marks a significant milestone in the delivery of change to the provision of health and social care. The Public Bodies (Joint Working) (Scotland) Act 2014, which sets out the framework to implement health and social care integration came into force on 1 April 2016. As a result, 31 HSCPs are now in operation and managing over £8 billion of health and social care resource.
4. We decided to scrutinise the partnerships given their important role in the delivery of integration of health and social care. We note that increasing demand is being placed on these services due to demographic changes. We also recognise the financial challenges currently being faced which were summed up in Audit Scotland's report *Health and Social Care Integration*—

 “NHS boards and councils have faced several years of financial constraints and this is expected to continue in the coming years. There is a risk that, if NHS boards and councils seek to protect services that remain fully under their control, Integration Authorities may face a disproportionate reduction in their funding, despite the focus on outcomes that all partners should have. We have reported previously on increasing pressures on health and care budgets. This risk of budget overspends is a significant risk for Integrated Joint Boards.”¹
5. Due to the truncated timescale for consideration of the Scottish Government's draft budget this year we chose to focus our budget scrutiny on reviewing the budget setting process for HSCPs in 2016-17.
6. We recognise this is the first full year of operation for most of the HSCPs. At this early stage we have sought to gain insights into how they are currently operating, as they begin the process of delivering a shift to new models of care.
7. As part of our budget scrutiny we agreed to conduct a survey of all HSCPs to gather information on their initial stages of operation and to gain a useful baseline for future scrutiny. We are pleased all partnerships responded. We hope to

encourage a culture of openness and engagement with HSCPs as we continue to scrutinise their role over the parliamentary session. [A SPICe analysis of survey responses](#) has been produced.

8. In addition to the survey we held an evidence session on [4 October 2016](#) with representatives from HSCPs in Edinburgh, South Lanarkshire, Highland and Scottish Borders. This was followed by an evidence session with the Cabinet Secretary for Health and Sport on [25 October 2016](#).
9. This short report considers some of the main themes that arose during our budget scrutiny of HSCPs. It also briefly explores some of the themes and issues related to budgeting that have arisen in some of the other areas of the Committee's work to date.

Operating arrangements

10. As part of our work on HSCP budgets, we considered the accountability and operational arrangements of the two types of HSCP in operation. The first type of HSCP, the lead agency model, was adopted by Highland HSCP in 2012. Under this model the NHS board has responsibility for adult health and social care services, while the council has responsibility for children's community health and social care services. The second type of HSCP, the Integrated Joint Board (IJB) model, adopted by all 'new' integration authorities, delegates functions to the IJB which then commissions services from the appropriate partner.
11. In its reports on *Health and Social Care Integration* and *Social Work in Scotland* Audit Scotland raised the complexity of accountability and governance arrangements for IJBs. In its integration report Audit Scotland noted—

” “[...] there are potentially confusing lines of accountability and potential conflicts of interests for board members and staff. There is a risk that this could hamper the ability of Integration Authorities to make decisions about the changes involved in redesigning services. People may also be unclear who is ultimately responsible for the quality of care. In addition, Integrated Joint Board members need training and development to help them fulfil their role.”²
12. The SPICe analysis of the HSCP survey responses supported the concerns raised by Audit Scotland. It noted a number of IJBs had found adapting to the new arrangements challenging and the intended operational independence of the IJB had not been achieved in this budget cycle.
13. In evidence to the Committee, Edinburgh HSCP described how the budget setting process had been led by the NHS and local authority representatives, and did not

give sufficient recognition to the IJB financial plans. Scottish Borders made similar observations—

” “It is probably fair to say that in informing our IJB budget this year, the council undertook its exercise, the NHS undertook its exercise, then the partnership brought those together.”³

14. East Dunbartonshire HSCP felt greater autonomy for the IJB was required and the Board did not fully understand its role and required further training. North Ayrshire HSCP suggested “cross sector barriers” between the local authority and health board could be removed by direct funding of IJBs by the Scottish Government.⁴
15. We heard from a representative of NHS Highland who had had experience of both the lead agency model and the IJB model. NHS Highland told us—

” “[...] what makes the lead agency model powerful is that operational budgets, management and governance are entirely integrated into one body.”⁵

16. NHS Highland went on to explain having one management and governance system enabled them to “be very fleet of foot” in making decisions to change the staffing required to respond to local needs.⁶
17. However, there were some challenges faced under the lead agency model regarding lines of accountability. NHS Highland explained the council still retained responsibility for functions which were discharged by the health board.⁷
18. We asked the Scottish Government about the advantages and disadvantages of the different partnership approaches in terms of accountability arrangements. The Cabinet Secretary for Health and Sport told us—

” “I am not convinced that this is about structure and whether the lead agency offers better governance and accountability solutions than IJBs. Rather, I think that leadership is the most important thing.”⁸

19. Geoff Huggins, Director for Health and Social Care Integration, Scottish Government went on to explain—

” “[...] the areas that are moving fastest and doing best are those where greatest leadership is being shown. It is ultimately about leadership as well as the interdependence that integration is intended to build.”⁹

20. The Scottish Government suggested that initially under the lead agency model there had been issues regarding local authorities and health boards understanding what budget had been transferred and which services were covered.
21. The Scottish Government also suggested, regardless of the model chosen, the first year of operation presented challenges for health partnerships.¹⁰ The Scottish

Government's guidance to IJBs in the first year of operation accepted budgets would largely reflect existing budgets—

” “The initial sums should be determined on the basis of existing Health Board and Local Authority budgets.”¹¹

22. We recognise in their first year of operation challenges were to be expected for Integrated Joint Boards in establishing autonomy.
23. We believe IJBs have found adapting to the new arrangements challenging and the intended operational independence of the IJBs may not yet have been achieved. We recognise the understanding of the operational arrangements and relationships between the different parties will evolve over time.
24. We also believe it may be too early to compare and assess whether either the lead agency or Integrated Joint Board is the most effective model for Partnership operation.
25. However, we do believe the governance arrangements for IJBs may potentially be a barrier to them achieving autonomy in budget setting and delivering changes in models of care. We intend to return to the issue of governance arrangements in further detail as part of our ongoing work on HSCPs.
26. The Scottish Government considers leadership as a key component to ensuring IJBs deliver. It suggested the highest performing IJBs were those where the greatest leadership was being shown. We ask the Scottish Government to indicate how that is being measured and assessed. We also ask the Scottish Government to provide further information on what support it is providing to IJBs which are not showing this successful leadership to support and assist IJBs in developing their performance.
27. We also seek assurance from the Scottish Government that the in-year financial reporting systems which are in place to monitor the allocation and spending by HSCPs can provide real-time information throughout the year.

Shifting the balance of care

28. In its report on health and social care integration, Audit Scotland stated integrating health and social care services has been a key government policy for many years, but to date there has been limited evidence of a shift to more community-based and preventative services.¹²

29. HSCPs have been tasked with delivering transformational change to the provision of health and social care. The long-term ambition of integration is to support a shift in the balance of care from the acute to the community sector. The Cabinet Secretary described this as a “radical service redesign” and “one of the most ambitious programmes of work” the Scottish Government has undertaken.¹³
30. We explored the progress made to date in the delivery of this transformational change. We recognise it is too early to expect to see any discernible shift in expenditure from hospital to community care. Our survey of HSCPs therefore asked how HSCPs plan to achieve this shift over the longer term. Partnerships were asked to give specific examples of projects that were designed to help achieve this.
31. The SPICe analysis of the survey responses highlights that many HSCPs gave very broad descriptions of how they would plan to shift resources, referring to preventative spend and investment in community services. Some HSCPs gave more specific examples.
32. Both Highland and Midlothian referred to the development of specialist housing to help address complex care needs within the community. North Lanarkshire referred to redesign of its IV drug treatment service so 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.¹⁴
33. 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. The SPICe survey analysis highlighted this was the only example given in the responses of a specific saving resulting from investment (although the financial value of the bed days saved was not given).¹⁵
34. Edinburgh provided specific examples of closures in the acute sector and service redesign resulting in more community based care. The Edinburgh HSCP representative spoke positively about the changes in the relationship between the NHS board and local authority staff as a result of the establishment of the HSCP.¹⁶
35. It explained the partnership provided a formal basis on which the NHS board and local authority could engage, debate and resolve issues. He explained there had been a cultural change that had taken a while to embed —

 “Because we [NHS board and local authority] are working hard together [...] the objective is shared between us, much more innovation is coming in, as well as much more willingness to share budgets, responsibilities and accountabilities.”¹⁷
36. South Lanarkshire HSCP considered there to be two aspects in which IJBs assisted in shifting the balance of care. First, the management and overview of the finances and the integrated budget. Second, the direction provided by the strategic commissioning plans.¹⁸ South Lanarkshire suggested success in shifting

the balance of care may be masked by demographic changes and the pressure on the acute sector making the shift in care harder to identify.¹⁹

37. Highland Partnership suggested in its survey response as a result of four years of integration, they had delivered a shift in resource from institutional care to home-based care and they would expect this shift to continue. Highland noted the “artificial divide” between health and social care budgets was gone.
38. Highland Partnership also provided follow-up evidence to the Committee to demonstrate the shifts were beginning to occur in their budget allocation. This information showed the share of the Highland Partnership budget being spent on community-based care, as opposed to institutional-based care had risen from 43% in 2011-12 to 48% in 2014-15.²⁰
39. We asked the Cabinet Secretary when we could expect to see a shift in the balance of resource for IJBs. She stated there was an expectation changes would be made in the allocation of resources in next year’s budget. There had been a roll-forward of individual service budgets used for the initial allocation to IJBs. However, she explained that there was an expectation in year two that the budget setting process would be based on negotiation about the level of funding, performance and associated risks to achieve a shift in the balance of care.²¹
40. The Cabinet Secretary also made reference to the review currently being conducted by Sir Harry Burns on NHS targets and performance management. The Cabinet Secretary emphasised the role performance measures could play in helping shift resources into more preventative spend—

” “If the Government sets targets for what we expect boards to deliver, resources will follow the targets. If the targets change and become more outcomes based, we expect integration authorities to prioritise their resources in the context of those outcomes. I hope that will help to shift the balance of care and to shift resources into more preventative spend and keeping people out of hospital.”²²

41. While we appreciate the remit of the review of NHS targets we are interested in the extent to which targets and indicators will be used to drive outcomes and the impact this will have on budgets. We have a particular interest, as set out in our strategic plan, in the impact on outcomes for patients and the extent to which this has a positive effect on health inequalities. We ask the Scottish Government to make this clear within the context of this and future budgets.
42. Shifting the balance of care is the ultimate aim of integration. We recognise shifting resources and care to the community sector is a transformational change which requires time to deliver. The expectation is that in the next financial year there should be evidence of changes made in the allocation of resources. This will require more negotiation, discussion and resourcing

than the approach that was taken to setting HSCPs' budgets in the first full year of operation. We ask the Scottish Government to provide further detail on what support it is providing to NHS boards, local authorities and HSCPs to ensure this can be delivered.

43. There are clear examples of HSCPs, in partnership with other agencies, undertaking work and delivering projects and policies which seek to shift the balance of care. It is also important to be able to determine what a successful outcome looks like in terms of the respective shares of the budgets being spent on community as opposed to institutional care. We note that Highland Partnership has been able to provide evidence on this shift as a proportion of its budget allocation. We ask the Scottish Government to provide a breakdown of the respective shares of the budgets it would expect to see HSCPs allocate in the next financial year. We believe this approach will assist in incentivising HSCPs and also provide a clearer roadmap on what progress is expected to be made and by what point.

Budget setting process

Timescales for agreement

44. A key area of interest for us in relation to HSCP budgets was to consider the processes and timescales for agreement of their budgets for 2016-17. The findings from our HSCP survey showed the majority of partnerships had not finalised their budgets prior to the start of the 2016-17 financial year.
45. According to the responses, only 11 of the 31 HSCPs had finalised their budgets before April 2016. A further nine had agreed their budgets by June and another eight by September. Three HSCPs (Edinburgh, Renfrewshire and South Ayrshire) stated at the time of responding to our survey in August 2016 they had yet to agree a final budget. In evidence to the Committee on 4 October 2016, Edinburgh's representative noted that the HSCP budget was expected to be agreed "in the coming months and definitely before Christmas".²³
46. We explored the reasons for the delays in HSCP budget setting. The majority of HSCP survey responses noted a key challenge to agreeing budgets was the different budget cycles of health boards and local authorities.
47. Partnerships indicated that, whilst local authority settlements are usually agreed in December, NHS board allocations are usually agreed in February. This difference in timescales meant there were challenges in agreeing HSCP budgets prior to the start of the financial year.
48. We also learnt the timescales for agreeing NHS board budgets was extended for 2016-17. NHS boards are required to set out how they intend to allocate resources in their local delivery plans (LDPs). These are informed by annual

guidance from the Scottish Government and submitted to the Government for agreement normally in mid-March. However the deadline for submissions of LDPs for the 2016-17 budget was extended to the end of May.

49. In contrast, 16 councils had set their budgets before the Local Government Finance Order was agreed by the Parliament on 25 February 2016.
50. Audit Scotland has highlighted the issue of non-aligned budget cycles. Its report on health and social care integration stated NHS budgets and allocations can change during the financial year and that, if different planning cycles between NHS boards and local authorities remain—

” “Integrated Joint Boards will be involved in protracted negotiations for budgets and ultimately cannot expect partners to approve their plans until just before the start of each financial year.”²⁴

51. Several HSCPs including Borders called for a timescale that allowed the HSCP budget to be set by 1 April each year. Edinburgh referred to the current non-alignment of the budget cycle as “not helpful”.²⁵
52. In evidence with the Scottish Government, we explored the reasons why the current budget setting processes were not aligned and whether changes were expected for the next financial year.
53. The Scottish Government explained the deadline for setting LDPs for the NHS board budgets for 2016-17 was extended because it was the transition year and the need for NHS boards to work with IJBs.²⁶ The Scottish Government stated it was not envisaged a three month extension would be required for budget setting in the coming financial year.²⁷
54. The Cabinet Secretary explained the Scottish Government was working with health boards, local authorities and integration authorities on guidance on good practice for budget setting. So for 2017-18 “the processes will be better aligned”.²⁸
55. The Scottish Government referred to evidence of closer working between chief officers and chief finance officers on budgets for HSCPs for the next financial year. The Scottish Government explained that as a result it was expected some boards would have indicative budgets for HSCPs in place by December 2016-January 2017.

56. It is disappointing in the first full year of operation, the majority of HSCPs started the financial year without a finalised budget in place. It is also concerning we found examples of HSCPs where budgets were still not in place in October for the current financial year. However, we do recognise as this is the first year of operation the change in relationships and approach to budget setting was always going to present challenges in terms of determining budgets before the start of the financial year.

57. The delay in HSCPs agreeing their budgets has implications for service delivery and achieving transformational change in health and social care. We therefore welcome the comments from the Scottish Government that it will seek to bring the budget setting processes for NHS boards and local authorities into better alignment for the next financial year and this will be supported by guidance on good practice. We recommend realigning budgets should not just be encouraged by the Scottish Government but there should be a clear commitment by the Scottish Government to ensure NHS boards set their budgets in alignment with local authorities.
58. To deliver on this commitment we recommend the Scottish Government should build on the good practice guidance it is developing and work with NHS boards and HSCPs on agreeing a new timetable for the budget setting process. The new timetable should detail the milestones needed to be achieved by specific points in the process and any changes the Scottish Government will need to make in its approach to signing off NHS boards' LDPs.

Social Care Fund

Approach to allocation

59. In its 2016-17 draft budget, the Scottish Government announced a £250m social care fund to be allocated to HSCPs via health boards specifically to address social care.
60. Whilst the funding was welcomed by HSCPs many survey responses stated 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.²⁹
61. There was also some criticism of the way the funding had been allocated. East Dunbartonshire HSCP noted the allocation of ring-fenced funding undermined the principle of “money losing its identity”.³⁰
62. In its survey response Highland Partnership noted the allocation of the social care fund failed to reflect the lead agency model. Highland told us in oral evidence “it would have been helpful to have had the guidance about how to use the £250m earlier than we did”.³¹
63. In oral evidence, the representative from South Lanarkshire's HSCP noted—

” “The social care fund is very welcome, but initially it was difficult to work out how to apply for it and how to work on it. That was a challenge for the partnerships.”³²

64. Edinburgh HSCP also suggested the guidance had “been open to interpretation”. It noted the plans presented by City of Edinburgh Council for using its share of the £250m fund did not comply with the ministerial guidance and they were in discussion with the Scottish Government to resolve this.³³

65. We believe the late timing of the allocation of the social care fund and initial lack of clarity on how the funding was to be used presented real challenges for HSCPs in agreeing their budgets. Taking these concerns into account we ask the Scottish Government to provide information on how it intends to handle any future social care allocations particularly in respect of: the timings of allocations; the routing of allocations (via health boards or local authorities), and the guidance on the use of social care funds. We also ask the Scottish Government to respond to the suggestion that providing ring-fenced funding undermined the principle of “money losing its identity”.

Scottish Living Wage

66. The social care fund was intended, in part, to support HSCPs in ensuring a living wage is paid to all social care workers.
67. The issue of the living wage was first raised during our work on the social and community care workforce. Annie Gunner Logan, Director Coalition of Care and Support Providers in Scotland told us providers like themselves had not been involved in determining the money allocated to the provision of the living wage. She raised concerns that the amount allocated did not include on-costs for employers, including national insurance and pension contributions and there was an assumption providers would make a financial contribution to its provision.³⁴
68. The Scottish Government published an analysis which stated “our estimate of the cost of increasing wages from current levels to Living Wage in 2016/17 is around £37m” based on implementation in October 2016.³⁵
69. In the HSCP survey integration authorities were asked how they used their allocation of the social care fund. Not all HSCPs provided a detailed breakdown of their use of the social care fund. The SPICe analysis of the HSCP survey responses details that 20 of the HSCPs gave information on the amounts they had allocated to implementing a Scottish living wage for all social care workers. In total, those 20 HSCPs had allocated £47.7m in 2016-17 for implementation from October 2016. Comparable information was not provided by other HSCPs.³⁶
70. We explored in oral evidence with the Scottish Government why this figure was well in excess of its estimated cost of £37m, noting the differential would be even greater if all HSCPs had provided details.
71. The Cabinet Secretary explained the Scottish Government’s £37m figure was an estimate for providing the Scottish living wage to staff in the independent and voluntary sectors, whilst the information provided by the HSCPs had also included

the uplift for council staff.³⁷ The exact coverage of all the HCSP figures is not always clear from the survey responses, but this may account for some of the difference.

72. The Cabinet Secretary went on to reiterate her commitment to delivering the Scottish living wage in future years and explained the Scottish Government's approach—

“We will – obviously - use the real-time information once all the deals have been completed and the financial information is available. We will have that real-time information to inform us in relation to where we go next year, and we are already beginning to have those discussions with local government.”³⁸

73. A specific issue explored in relation to the application of the Scottish Living Wage was whether sleepovers would be paid at the Scottish Living Wage.

74. This issue was first discussed with us during our work on the social and community care workforce. It was raised again within the context of HCSP budgets. We asked HCSPs about the extent to which sleepover shifts were covered in the payments being made to care providers. Scottish Borders stated—

“we are currently working through a number of technicalities on the implementation of the living wage with regard to sleepovers”.³⁹

75. The Cabinet Secretary also recognised the complexities around the delivery of the living wage for sleepovers and the importance of ensuring services for vulnerable people were not affected. The Cabinet Secretary did, however, state—

“I have made it clear that I want people who are being paid for sleepovers to be paid at the living wage rate, and that is the ambition.”⁴⁰

76. The Committee was told by the Scottish Government an event was due to take place in late November early December to discuss the approach to the issue of the Scottish Living Wage and provision of sleepover care.⁴¹

77. As discussed in our recent correspondence to the Scottish Government on the social and community care workforce we welcome the introduction of the Scottish Living Wage and the commitment made by the Cabinet Secretary to provide the living wage in future years.

78. We are keen to establish the final costs of the provision of the Scottish Living Wage in the current financial year to determine if there have been higher-than-estimated costs of implementation. We therefore ask the Scottish Government once the financial information is available at a partnership level on the actual costings of the Scottish Living Wage to provide us with a breakdown on the actual costs in comparison to the

estimated costs to determine if sufficient funding has been provided to ensure its delivery.

79. Central to ensuring continued provision of the Scottish Living Wage is ensuring the financial resources are there to support its delivery. We ask the Scottish Government to provide further information on how the costs will be met in future years. We also reiterate the request made in our letter to the Cabinet Secretary on the Social and Community Care Workforce for an update on the approach to the issue of the Scottish Living Wage and provision of sleepover care.

Long term budget planning

80. During oral evidence on the budget setting process we heard some views that allocating funding on an annual basis presented limitations.
81. For example, several HSCPs felt there should be more opportunity for longer term financial planning. In evidence a South Lanarkshire HSCP representative commented that, whilst strategic plans lasted three years, this presented challenges as HSCPs' funding was provided on an annual basis. South Lanarkshire suggested consideration should be given to whether there was the scope and capacity to bring the strategic and budget plans together.⁴²
82. Highland HSCP believed there was merit in having an indicative budget for the three year period, whilst recognising it may be subject to change.⁴³
83. In its recent report on NHS in Scotland 2016, Audit Scotland also highlighted the benefits of long term financial planning. It recommended consideration should be given to providing NHS boards with more financial flexibility such as three-year rolling budgets rather than annual financial targets, to allow better longer-term planning.⁴⁴
84. The Cabinet Secretary responded to Audit Scotland's recommendation in a statement to the Scottish Parliament—



“We will consider the Audit Scotland proposal for three-year budget management as part of our work to examine how to provide NHS boards with more financial flexibility and within the context of the accounting and financial management framework that is set by the Treasury.”⁴⁵

85. We believe uncertainty regarding longer-term funding for HSCPs presents challenges for them in developing their long term strategic plans.

86. We note the commitment made by the Cabinet Secretary to consider the proposal for three year budget management for NHS boards. We welcome this commitment. We hope in turn consideration will also be given to whether more can be done to assist longer-term financial planning for HSCPs. While recognising long term funding proposals would need to be indicative in nature and subject to revision depending on the overall fiscal settlement. We believe this would provide greater flexibility and assist with long term strategic planning if indicative budgets were provided to HSCPs for a longer time frame than the current annual budgeting approach.

Financial and performance reporting

87. HSCPs are required to provide financial and performance reports from this financial year. HSCPs are required to contribute towards nine 'National health and wellbeing outcomes' set by the Scottish Government. In addition, there are 23 'core integration indicators' set out by the Scottish Government to support these outcomes.
88. HSCPs will be required to report annually on how their activities have contributed towards meeting the nine outcomes. The intention is these performance reports will include financial information on how resources have been allocated to specific outcomes.
89. Our survey asked HSCPs to show how their budgets linked to these national outcomes. As detailed in the SPICe analysis of the survey responses only one HSCP, Aberdeenshire, made any attempt to link budgets to the performance framework, although the linkages were to the strategic priorities rather than the national outcomes.
90. Some HSCPs stated they were working towards linking budgets and outcomes during the current financial year. However, the majority of HSCPs provided no budgetary information alongside their performance framework.⁴⁶
91. Several HSCPs detailed the difficulties in linking budgets and outcomes. South Lanarkshire HSCP summed up the views held by several HSCPs on the challenges in adopting this approach—
- ” “The exercise we faced in the summer, which was about allocating the funding to the outcomes, was particularly tricky, because a number of activities that we undertake might have a range of outcomes. Some are difficult to track from input to outcome and some are very tricky to allocate funding to.”⁴⁷
92. Edinburgh's HSCP representative made comments that suggested they were not aware the Scottish Government would require them to report in this way—



“It is impossible to [link budgets to outcomes] because the outcomes are interrelated. The actions that we fund will cover a range of those outcomes, so doing the exercise that splits up £1million being spent on prescribing or whatever is not useful [...] It is too simplistic to expect us to divide up our budgets according to the outcomes [...] we would not go down to the level of detail that was requested of us for each of those outcomes. It would not serve your purpose or ours to do that.”⁴⁸

93. We welcome and support the requirement made by the Scottish Government that HSCPs must link budgets to the performance framework.
94. However, we are concerned by the evidence we have received from HSCPs about the challenges in achieving this linkage between budgets and the performance framework. We are also concerned there appears to be a lack of awareness and understanding of the need for such reporting by HSCPs.
95. We recognise there are challenges associated with measuring and collating this information. We believe there is real value in this work being conducted to enable an assessment to be made of the effectiveness of spending to deliver on specific outcomes and a clear indication of the prioritisation of spending. We therefore recommend the Scottish Government provide HSCPs with clear parameters in which to measure and quantify HSCP budgets against specific outcomes. We ask for further information from the Scottish Government on the steps it will take to ensure the budget financial and performance reporting is conducted on a consistent basis across all HSCPs.
96. We will be monitoring closely the extent to which annual reports provide this information which we consider vital to understanding the impact of budget on outcomes. To that end we would welcome a report from the Scottish Government on the compliance by HSCPs, together with detail indicating the inter-relation between spend and the delivery of outcomes and the desired transformational change.

Other financial issues arising from inquiry work

97. As well as conducting specific work on the scrutiny of HSCPs budgets we have sought to build an element of budget scrutiny into all the work we have conducted so far. The Committee has made several specific recommendations on financial issues to the Scottish Government on some of the topics we have considered to date. Discussed below is a brief summary of some recurring themes and issues.

98. One such theme has been the importance of being able to determine spend on a specific policy area. We believe having this financial information is important to be able to assess the effectiveness of spending. In our [letters to the Cabinet Secretary on Delayed Discharge](#) we highlighted concern that, if the overall spend on the issue of delayed discharge was unknown, it is difficult to assess the efficiency and effectiveness of spending on delayed discharges.
99. We have also considered the issue of resource allocation in relation to the different aspects of the health care system. In our recent [letter to the Cabinet Secretary on Primary Care in Scotland](#) we referenced the evidence we heard about the reduction in the proportion of the budget allocated to primary care in recent years. We welcomed the Scottish Government's ambition to increase the percentage of overall central health spending in primary care to 11%. We also asked the Scottish Government to provide an indication of when it would expect this ambition to be reflected in the Scottish Government's budget.
100. Health inequalities is an important strand to all our work. In relation to our work on primary care we indicated our support for changes to the Scottish allocation formula to better reflect the health inequality dimension of practices' populations. We stated that we looked forward to receiving further detail on how that is to be achieved in the next round of allocations.
101. Another important theme to our work is the importance of preventative spend. As part of our strategic plan we have committed to scrutinise policy issues in relation to their preventative focus. As discussed earlier in this report ultimately shifting the balance of care is about moving resources towards preventative spending. These changes are imperative if, given current demographics and financial challenges, appropriate care is to be provided to the population. This was a point reiterated in our recent letter on primary care in Scotland.
102. In this letter we recognised—
- “there is a growing consensus the NHS needs to focus on the development of preventative models of care. This is driven by the on-going financial challenges facing the health care system, with rising demand and relatively flat funding in real terms. Such approaches focus on proactive rather than reactive management of patients with long term conditions and multi-morbidities. Clearly GPs are at the centre of care provided in the community, and are able to influence the level of demand for other care settings.”⁴⁹
103. We requested in our letter details from the Scottish Government of the ways in which preventative spending is being evaluated and its cost effectiveness assessed.
104. We called for similar information in relation to our work on delayed discharge. We asked how much of the spend on a delayed discharge is allocated to preventative

spend measures and how outcomes from the spend and value for money is being assessed.

105. Preventative spend is a recurring issue in our work. We are keen to determine what is being allocated to preventative policies, how it is being evaluated and its cost effectiveness assessed. We ask the Scottish Government to provide detail on ways this can be reflected in its draft budget.

106. It is also important to be able to determine if the Scottish Government's budget is having a positive impact on reducing health inequalities. We ask the Scottish Government to provide detail on the ways this can also be reflected in its draft budget. We also ask for an assurance that the new financial and performance reporting system for HSCPs will enable an assessment to be made on whether spending is being successfully targeted and reducing health inequalities.

¹ Audit Scotland (December 2015) [Health and Social Care Integration](#).

² Audit Scotland (December 2015) [Health and Social Care Integration](#).

³ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2016, Col 16.

⁴ SPICe [Survey of 2017-18 Integration Authority budget plans analysis](#)

⁵ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2016, Col 2.

⁶ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2016, Col 3.

⁷ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2016, Col 3.

⁸ Scottish Parliament Health and Sport Committee. *Official Report*, 25 October 2016, Col 17.

⁹ Scottish Parliament Health and Sport Committee. *Official Report*, 25 October 2016, Col 18.

¹⁰ Scottish Parliament Health and Sport Committee. *Official Report*, 25 October 2016, Col 18.

¹¹ Scottish Government Guidance to Integration Authorities.

¹² Audit Scotland. Health and Social Care Integration December 2015. Para 2.

¹³ Scottish Parliament Health and Sport Committee. *Official Report*, 25 October 2016, Col 6.

¹⁴ SPICe [Survey of 2017-18 Integration Authority budget plans analysis](#)

¹⁵ SPICe [Survey of 2017-18 Integration Authority budget plans analysis](#)

¹⁶ SPICe [Survey of 2017-18 Integration Authority budget plans analysis](#)

¹⁷ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2016, Col 5.

¹⁸ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2016, Col 6.

¹⁹ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2016, Col 6.

²⁰ Highland Partnership. Written submission October 2016.

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- ²¹ Scottish Parliament Health and Sport Committee. *Official Report*, 25 October 2016, Col 11.
- ²² Scottish Parliament Health and Sport Committee. *Official Report*, 25 October 2016, Col 25.
- ²³ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2016, Col 14.
- ²⁴ Audit Scotland (December 2015) [Health and Social Care Integration](#).
- ²⁵ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2016, Col 17.
- ²⁶ Scottish Parliament Health and Sport Committee. *Official Report*, 25 October 2016, Col 11.
- ²⁷ Scottish Parliament Health and Sport Committee. *Official Report*, 25 October 2016, Col 12.
- ²⁸ Scottish Parliament Health and Sport Committee. *Official Report*, 25 October 2016, Col 11.
- ²⁹ SPICe [Survey of 2017-18 Integration Authority budget plans analysis](#)
- ³⁰ SPICe [Survey of 2017-18 Integration Authority budget plans analysis](#)
- ³¹ SPICe [Survey of 2017-18 Integration Authority budget plans analysis](#)
- ³² Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2016, Col 18.
- ³³ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2016, Col 20.
- ³⁴ Scottish Parliament Health and Sport Committee, *Official Report*, 13 September 2016, Col 13-14
- ³⁵ Scottish Government 'Progress towards the Living Wage', SPICe Bib no. 57809
- ³⁶ SPICe [Survey of 2017-18 Integration Authority budget plans analysis](#)
- ³⁷ Scottish Parliament Health and Sport Committee. *Official Report*, 25 October 2016, Col 31.
- ³⁸ Scottish Parliament Health and Sport Committee. *Official Report*, 25 October 2016, Col 31.
- ³⁹ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2016, Col 20.
- ⁴⁰ Scottish Parliament Health and Sport Committee. *Official Report*, 25 October 2016, Col 28.
- ⁴¹ Scottish Parliament Health and Sport Committee. *Official Report*, 25 October 2016, Col 29.
- ⁴² Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2016, Col 6.
- ⁴³ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2016, Col 17-18.
- ⁴⁴ Audit Scotland (October 2016) [NHS in Scotland 2016](#)
- ⁴⁵ Scottish Parliament. *Official Report*, 2 November 2016.
- ⁴⁶ SPICe [Survey of 2017-18 Integration Authority budget plans analysis](#)
- ⁴⁷ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2016, Col 23.
- ⁴⁸ Scottish Parliament Health and Sport Committee. *Official Report*, 4 October 2016, Col 24.
- ⁴⁹ Deloitte report for the RCGP "Spend to save: the economic case for improving access to general practice" 2014.

Annexe A

Extracts from the minutes of the Health and Sport Committee and associated written and supplementary evidence.

2nd Meeting, 2016 (Session 5) Tuesday 28 June 2016

2. Work programme (in private): The Committee considered and agreed its work programme.

7th Meeting, 2016 (Session 5) Tuesday 4 October 2016

2. Health and Social Care Integration budgets: The Committee took 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 considered the main themes arising from the oral evidence heard earlier in the meeting.

Written Evidence



Edinburgh Health and Social Care Partnership



South Lanarkshire Health and Social Care Partnership



Highland Partnership



Scottish Borders Health and Social Care Partnership

Supplementary Written Evidence



NHS Highland

8th Meeting, 2016 (Session 5) Tuesday 25 October 2016

3. Health and Social Care Integration budgets: The Committee took evidence from—

Shona Robison, Cabinet Secretary for Health and Sport, Geoff Huggins, Director of Health and Social Care Integration, and Christine McLaughlin, Director of Health Finance, Scottish Government.

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

12th Meeting, 2016 (Session 5) Tuesday 22 November 2016

5. Health and Social Care Integration budgets (in private): The Committee considered a draft report. Various changes were agreed to, and the Committee agreed to consider a revised draft, in private, at a future meeting.

13th Meeting, 2016 (Session 5) Tuesday 29 November 2016

5. Health and Social Care Integration budgets (in private): The Committee considered and agreed a draft report.

List of other Written Evidence

-  Shetland Islands Health and Social Care Partnership
-  Glasgow City Health and Social Care Partnership
-  Angus Health and Social Care Partnership
-  Western Isles Health and Social Care Partnership
-  East Lothian Health and Social Care Partnership
-  Midlothian Health and Social Care Partnership
-  Orkney Health and Social Care Partnership
-  West Lothian Health and Social Care Partnership
-  East Ayrshire Health and Social Care Partnership
-  Dumfries and Galloway Health and Social Care Partnership
-  Aberdeenshire Health and Social Care Partnership
-  North Ayrshire Health and Social Care Partnership
-  Argyll and Bute Health and Social Care Partnership
-  Aberdeen City Health and Social Care Partnership
-  Moray Health and Social Care Partnership
-  East Renfrewshire Health and Social Care Partnership
-  Falkirk Health and Social Care Partnership
-  East Dunbartonshire Health and Social Care Partnership
-  West Dunbartonshire Health and Social Care Partnership

-  [Clackmannanshire and Stirling Health and Social Care Partnership](#)
-  [North Lanarkshire Health and Social Care Partnership](#)
-  [Dundee Health and Social Care Partnership](#)
-  [Renfrewshire Health and Social Care Partnership](#)
-  [Fife Health and Social Care Partnership](#)
-  [Perth and Kinross Health and Social Care Partnership](#)
-  [South Ayrshire Health and Social Care Partnership](#)
-  [Inverclyde Health and Social Care Partnership](#)

SPICe analysis of survey responses

The Scottish Parliament Information Centre produced an analysis of the 31 survey responses received.

-  [Survey of 2017-18 Integration Authority budget plans](#)

