ADSW
ASSOCIATION OF DIRECTORS OF SOCIAL WORK

RESOURCE TRANSFER DRAFT PROTOCOLS

RESPONSE TO CONSULTATION

The Association of Directors of Social Work supports the work being undertaken to stabilise Resource Transfer and welcomes the opportunity to comment on the draft protocols. Our responses cover the specific questions in the Consultation Paper.

As we state in our response to Question 6 (and repeat here), a much wider imperative dwarfs the narrower issue of Resource Transfer uplifts. It is clear that the NHS and Councils need to work very closely to jointly manage public expenditure reductions with other community planning partners. The effectiveness and efficiency of the NHS depends on a sufficient volume and quality of social care services. There is a strong argument for further NHS financial support to fund reablement and rehabilitation, crisis support, respite care/ support to carers, and other social care services that prevent hospital admission and facilitate early discharge. That in turn requires stronger leadership both nationally and locally to achieve the disinvestment in acute services required to fund preventative and community based services that will reduce pressures on the NHS.

Measurement

1. *The Public Audit Committee recently indicated that it was unsatisfied with the accuracy and consistency of resource transfer statistics. Do you agree that it would be useful to acquire a more accurate measure of resource transfer across Scotland?*

Yes, ADSW agrees with these criticisms. Resource Transfer is an important mechanism for the NHS and local authorities to achieve shared care objectives and value for money. The sums involved are significant: the 2008-09 local authority financial returns show that councils in Scotland received income of around £343 million from the NHS, about 10% of their total gross expenditure of £3.4 billion on social work services, much of which prevents or delays hospital admission.

The quality and consistency of the Resource Transfer statistics collected by ISD is quite poor, with a lack of consistency in the data over time and between health boards. (The LFR3 figures quoted above have similar problems and also do not distinguish Resource Transfer from delayed discharge and other funding from health boards).

We believe these problems could be remedied by establishing a short-life working group to redesign the ISD statistical collection around clear definitions (based on those in para 16 of the Consultation Paper), without adding to the reporting burden. Data supplied by health boards could usefully identify the councils to which the resources were transferred.

Recommendation: establish a short-life working group, including Scottish Government, ISD, Health Board and Council representation, to redesign the ISD statistical collection for Resource Transfer.

Definition

2. *The draft Protocols propose defining Resource Transfer as agreed sums of money transferred from Health Boards to Local authorities to provide community based services as an alternative to long-stay inpatient care. The sums of money are generally tied to long-stay hospital closures or bed reductions, often going back to the 1990s. Do you agree with this definition? Does it remove uncertainty about what Resource Transfer covers?*

We agree with this definition, with a small amendment to the end of the first sentence to: "*as an alternative to long-stay or respite inpatient care*", to reflect the fact that in some areas Resource Transfer has also included the closure of NHS respite beds.

We believe this will remove uncertainty about what Resource Transfer covers only when taken together with the description in paragraph 16 of the Consultation Paper of other types of NHS financial transfers to local authorities. Taken together, this provides a clear statement of what Resource Transfer *is*, and what it *isn't*: both are needed for clarity.

Locus

3. Is the attached document sufficiently clear about the locus of resource transfer discussions, i.e. primarily a function of the health board rather than the CHP? Do you agree with this position?

We agree that Resource Transfer discussion within the health service is primarily a function of the health board and not of individual CHPs. This reflects the role of the board's chief executive as the accountable officer.

Timing of Negotiations

4. Recognising that Scottish Government NHS finance letters are typically issued in March each year, there may be challenges in agreeing resource transfer allocations before the beginning of the financial year. If this timing issue can be resolved, do you agree that discussion about resource transfer allocations should be undertaken in line with local authority budget setting processes?

We agree that it is essential that Resource Transfer discussions are undertaken and concluded in line with council budget setting processes by early February each year. The financial interface between the NHS and local authorities is, of course, much wider than Resource Transfer. Many local authority services contribute directly to the health of their populations, in addition to the support provided to the NHS by council social care services. Aligning NHS and Local Authority budgetary timescales is necessary to support the policy of greater integration between NHS and local authority services.

We recommend that the Scottish Government further consider, with NHS Boards and COSLA, the alignment of timescales for public expenditure forward planning and budgetary decision making by health boards and councils.

Uplifts

5. Recognising that there have been a range of disputes about inflationary uplifts, would you prefer the annual uplift to be identified nationally (with appropriate political endorsement) or left for local discussion using nationally defined criteria?

A national formula for resource transfer uplifts is attractive as a device for calming local negotiations, allowing attention to be more clearly focussed on current and future work to jointly plan and redesign services to shift the balance of care from in-patient to community health and social care services, and achieve better outcomes for people at lower cost. However, ADSW recognises that developing such a formula is not easy.

At the very least, "nationally defined criteria" for local discussion would require the Scottish Government to make public each year the assumptions used for both the NHS and Local Authority resource allocations, in relation to:

- pay and price inflation, including separate identification of any special issues
- efficiency and other savings, and
- demography.

The uplift discussions, and partnership working more generally, require greater transparency.

6. *Which of the following criteria do you think should be used to inform the annual resource transfer uplift?*

a) the total uplift provided by the Scottish Government to Health Boards
b) the total uplift provided by the Scottish Government to Councils
c) the mid-point between the uplift provided by the Scottish Government to Health Boards and Councils
d) the GDP deflator
e) An agreed composite of council pay and supplies inflation
f) The average uplift Councils pass on to independent sector care providers;
g) The total uplift provided by the Scottish Government to Health Boards minus jointly agreed efficiency savings identified by councils and health boards (see Annex A);
h) A combination of the above; or
i) Some other uplift formula - please describe

The answer to this question depends on question 7 below about whether Resource Transfer should be exempt from "efficiency savings". If it is exempted, then ADSW would prefer option (a); but if it is not exempted, then option (j) would be preferred, defined as the net effect of NHS inflation uplifts and savings targets (with varied wording if Resource Transfer were partially exempted).

Health Boards can only transfer money that they have; therefore, the base uplift should be the (net) uplift provided by the Scottish Government to Health Boards. We see no rationale for the "equal pain principle" proposed in option (g) and in Annex A whereby the mid-point of NHS and Council savings targets is used. Logically (if not politically) there are three possibilities:

(i) greater financial protection for the NHS than for Local Government;
(ii) equal financial protection, with their current respective percentage shares of (decreasing) Scottish public expenditure maintained;
(iii) greater financial protection for Local Government than for the NHS.

Under the first scenario, future Council net savings targets will be higher than those for the NHS, so the mid-point proposal would deliver a smaller uplift than the NHS could afford, resulting in a corresponding reduction in the social care services that are relieving pressures on NHS beds by helping to prevent hospital admission, or facilitating earlier discharge. That seems perverse.

The "equal pain principle" is redundant under the second scenario, while the third is extremely unlikely and would require the NHS to give more protection to Resource Transfer than to the totality of NHS services.

It is worth noting that Option (a) would still leave some work to be done *nationally* to identify any elements within NHS pay and price uplifts that should not apply to Resource Transfer, such as (historically) uplifts to cover the new GP contract or pay modernisation. It would also leave work to be done *locally* to jointly agree whether the uplift was sufficient to cover any price inflation in services funded by Resource Transfer; whether the Health Board intended to apply national savings targets equally to its services or provide some protection to community health services in line with shifting the balance of care; and how the local authority intended to apply its own savings targets to the wider set of local authority social care and other services that support the NHS.

It is clearly important to take this opportunity to resolve issues about Resource Transfer uplifts. However, we also need to bear in mind that this is just a part of a much bigger issue. It is clear that the NHS and Councils need to work very closely to jointly manage public expenditure reductions with other community planning partners. The effectiveness and efficiency of the NHS depends on a sufficient volume and quality of social care services. There is a strong argument for further NHS financial support to fund reablement and rehabilitation, crisis support, respite care/ support to carers, and other social care services that prevent hospital admission and facilitate early discharge. That in turn requires strong leadership locally to achieve the disinvestment in acute services required to fund preventative and community based services that will reduce pressures on the NHS.

7. *Insofar as both councils and health boards will be required to find efficiencies, do you agree that resource transfer payments ought* ***not*** *to be exempt from this process?*

There are a range of views on this question within ADSW. It is more difficult to achieve efficiencies from existing care packages or services funded by Resource Transfer than from new services jointly planned and agreed. For purchased care services it may not be possible to renegotiate existing contracts; for example, fee levels for purchased care home placements for older people are determined by the national care homes contract. Councils also feel that they are picking up the costs of increased demand, due to demographic change, which would have previously fallen on the long-stay NHS beds whose closure led to Resource Transfers. There is greater support, therefore, for restricting efficiencies to *new* Resource Transfer agreements.

Resource Transfer efficiencies is a much bigger issue for Councils than for the NHS. At around £315m in 2008-09, according to ISD figures, Resource Transfer represents only 3.8% of total NHS spend in Scotland (at £8.394 billion). Whereas, as noted earlier, for Councils income from the NHS represents 10% of gross spend on all of social work services – the proportion is, of course, much larger for net spend on community care.

Protecting Resource Transfer from "efficiency targets" very much fits the Scottish Government's key "Shifting the Balance of Care" health and social care policy, covering health promotion, changing the emphasis from services focused on acute conditions towards systematic and personalised support for people with long term conditions; and providing more care and treatment in the community. Councils would continue to seek efficiencies from services funded by Resource Transfer and where achievable then part of the deal about uplifts could be that they are re-invested, rather than taken as savings.

Exempting Resource Transfer from savings targets would mean slightly higher targets for the rest of the NHS, illustrated below using the base figures quoted above for 2008-09:

Savings target	RT savings £'000	Rest of NHS savings target if RT exempt
1.00%	3,150	1.04%
2.00%	6,300	2.08%
3.00%	9,450	3.12%
4.00%	12,600	4.16%
5.00%	15,751	5.19%
6.00%	18,901	6.23%
7.00%	22,051	7.27%
8.00%	25,201	8.31%
9.00%	28,351	9.35%
10.00%	31,501	10.39%

Certainly for Councils, the term "efficiencies" is misleading: the scale of public expenditure reductions will go far beyond what can be achieved by further efficiency savings. If Resource Transfer is not exempt from the need to find savings, then there needs to be an acknowledgement by all concerned that some reductions in service volumes are inevitable. Each partner should have the ability to retain its own expenditure reductions to meet its own savings targets. Neither partner should make savings that are likely to increase the costs of the other partner without prior discussion and agreement. However, in the event that NHS funding is ring-fenced in the forthcoming public expenditure settlement, we would expect Resource Transfer to be exempt from savings and an inflationary uplift applied accordingly.

Disputes

8. Do you agree that in the event of dispute over resource transfer, it should be open to either party to call for external arbitration? If so, do you agree that an Executive Officer from another health board and council would be appropriate arbiters? Do you have a preferred alternative?

Yes, recourse to arbitration should reduce failure to agree, and a transparent national formula should also reduce the need for arbitration. Further thought is needed as to the identity of the arbiters to ensure independence and the actual choice of arbiters might need to be mutually agreed.

Partnership

9. Do you agree that neither health boards nor councils should unilaterally withdraw mutually committed resources, as per recommendation 6?

We agree that there should be no unilateral withdrawal of mutually committed resources, where this would have a material impact on the other partner. We also agree that "mutually committed resources" are much wider than services covered by current resource transfers, and cover all joint planning activity, as set out in Stage 2 of the protocols.

Governance

10. Are there any governance issues that require to be addressed with respect to resource transfer which the attached document does not consider? Do you agree with recommendation 7?

We have not identified any governance issues not already addressed in the paper. We agree with Recommendation 7 as a clear statement of the direction of travel, but there are clearly challenges in achieving the levels of transparent information sharing and genuine joint-decision making required, recognising the different lines of accountability within the NHS and local government.

Local Arrangements

11. Do you believe your local partnership arrangements are strong enough to support the protocols outlined below?

ADSW is not in a position to comment on partnership arrangements between individual councils and health boards. The IRF Pilots are likely to identify areas where partnership arrangements require to be strengthened. We would expect there to be some difficulties in resourcing the level of financial and service planning implied in the draft paper, and necessary to deliver useable outputs from the data mapping stage of IRF. The most important issue is clear leadership for the direction of travel.

MEL (1992) 55

12. Are there any other issues with the implementation of the original Resource Transfer guidance [in MEL (1992) 55] that the draft new Protocols should cover?

The original guidance envisaged that Resource Transfer would in time be consolidated within local authority financial allocations. Given the variation in Resource Transfer levels, and local difference in hospital bed reduction, it would be very difficult to establish an equitable resource allocation formula for Resource Transfer.

Final Comments

13. Are there any other comments you would like to make about the suggested protocols?

Partnership implies complete transparency about the realisable savings from future bed closure programmes, as well about the costs of sustainable community based alternatives, and joint agreement about how these savings are spent. There is no recognition in the protocols paper that not all savings from NHS bed closures have been (or can be) transferred to local authorities: some have been reinvested in NHS services, but often without discussions or agreement with local authority partners on the appropriate balance between NHS community services and Council social care.

Children and young people are missing from the list of "client groups" included in the more holistic approach outlined in paragraph 41.

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