Accounts Commission *for Scotland*

Shifting the balance

Resource transfer for community care

JUNE 1997

Contents

The Accounts Commission is a statutory, independent body which through the audit process assists local authorities and the health service in Scotland to achieve the highest standards of financial stewardship and the economic, efficient and effective use of their resources.

The Commission has five main responsibilities:

- securing the statutory external audit
- following up issues of concern identified through the audit to ensure a satisfactory resolution
- reviewing the management arrangements which audited bodies have in place to achieve value for money
- carrying out national value for money studies to improve economy, efficiency and effectiveness in the NHS and local authorities
- issuing an annual direction to local authorities setting out the range of performance information which they have to publish.

The Commission assists the NHS in achieving value for money by highlighting good practice, providing comparative information, and supporting auditors in reviewing performance locally. Its Health and Social Work Studies Directorate is responsible for managing a national programme of value for money studies. Part of the 1996 programme included a review of resource transfers in Scotland.

This report is based on a series of audits developed and managed by the Commission, and undertaken by local auditors at all 15 Health Boards and 12 Regional and Islands Councils. It took place during the period of local government reorganisation, focusing on expenditure during 1995-96. Its findings provide valuable pointers to the areas that are likely to require attention by their successor authorities in collaboration with their health board partners.

The study forms part of a series reviewing the implementation of community care. A second major report is planned for autumn 1997, examining how the new local authorities are developing their lead role in commissioning community care services. Further reports will follow up particular issues in more detail.

The resource transfer study was managed by John Porter under the general direction of Caroline Gardner, Director of Health & Social Work Studies. The Accounts Commission is grateful to all the individuals and organisations who assisted this study. Responsibility for the contents and conclusions rests solely with the Accounts Commission.

Executive summary

Community care is about enabling users of services to live as normally and independently as possible. It involves changing the context in which support services have traditionally been provided, by reducing reliance on institutional care so that people can live as far as possible in their own homes or in homely settings within the community.

The NHS and Community Care Act 1990 provides the statutory framework for the present policy of care in the community. In the year in which the Act was passed, there were around 29,000 long-stay places in Scottish hospitals for patients requiring a mix of health and social care. They included the elderly, and people with mental illness and learning disability (see exhibit1).

By 1995, through a programme of planned bed closures and transfers of patients to the community, this figure had fallen by a quarter to 21,000. The pace of change will continue as additional community places are created for all care groups over the latter half of the decade.

Exhibit 1: Available staffed beds in Scotland by care group

	1990	1995
Mental Illness	8351	5018
Geriatric	9132	6790
Psychogeriatric	5914	5688
Learning Disability	5283	3400
Total	**28680**	**20896**

Notes

1 Figures are for year ending 31 March.

2 Between 1990 and 1993 there was a reclassification of mental illness beds as psychogeriatric beds.

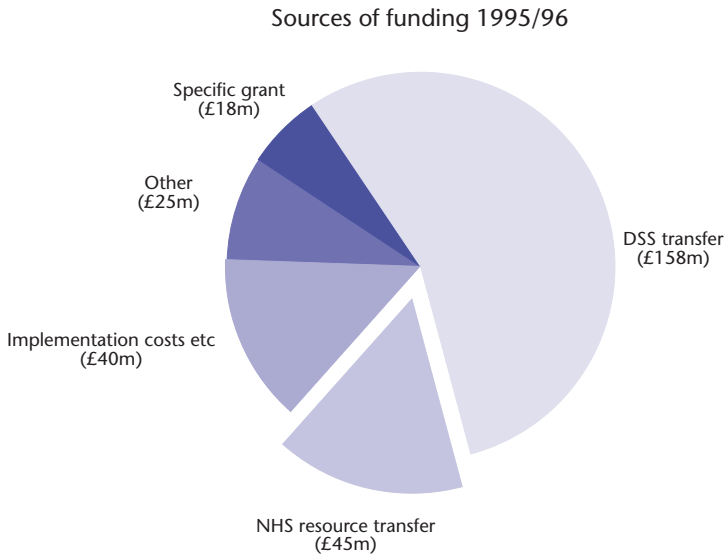
Source: ISD

Sources of funding

Reflecting the change in approach, the 1990 Act gave local authorities the lead responsibility for co-ordinating the provision of community services within their area. New sources of funding were generated to help finance the investment in community services (exhibit 2). This included a contribution of £45m from health boards in support of patients transferred from NHS beds (Appendix 1).

Exhibit 2: Funding of post-1990 responsibilities

Funds totalling £286m were made available to local authorities to supplement the substantial resources already within social work budgets and housing departments' capital allocations.



Source: The Scottish Office

It is important to note is that resource transfer is only one of a series of measures implemented since 1990 in support of the community care reforms. As the diagram shows, it accounted for a fairly modest slice (16%) of new monies made available prior to reorganisation to the nine mainland regional councils and the three islands councils.

In turn, these additional funds represent less than half of all expenditure by social work departments on community-based services in Scotland. Overall, this totalled in excess of £670 million in 1995/96.

The resource transfer scheme

"An important feature of the scheme is that health boards remain accountable for local authorities' use of transferred resources."

The main thrust of the current policy is that patients inappropriately accommodated in hospitals should be able to live in the community, and that inappropriate admissions to institutional care should be prevented. Because the objective is to assign lead responsibility for developing a range of care places in the community, resource transfer is essentially a contribution to the cost of providing specified services and is not linked to the care needs of individual patients.

Resource transfer is a means of using the savings from reductions in hospital provision to help finance the development of alternative services. Under the guidance issued by The Scottish Office in 1992 and 1993, the actual amounts to be transferred are a matter for negotiation between individual health boards and local authorities. An important feature of the scheme is that health board general managers remain accountable for local authorities' use of transferred resources.

Since the present arrangements were introduced, the value of resources transferred by health boards has risen from £8m in 1993/94 to £45m in 1995/96 and is likely to exceed £80m for 1996/97.

The expectation is that there will be an increasingly significant shift in resources from health boards to local authorities as the balance tilts further towards care in the community. Ultimately, it may peak at around £200 million a year. By that stage, the majority of people whose needs are mainly for social rather than medical or nursing care will have moved into the community.

The Commission's study was designed to examine the progress made in planning and effecting appropriate service changes, and to assess the arrangements in place to manage the transfer of resources. Audits were carried out at every health board and local authority in Scotland focusing on expenditure in 1995/96.

The study was primarily concerned with the implementation of the current guidance, and not with its effectiveness in wider terms. Thus, it did not cover issues such as the quality of service delivery, or whether the changes have resulted in better use of the resources being transferred.

What we found

For the shift in services to succeed, health boards need to secure a consensus with their social work and other partners on the objectives and priorities for community care. The evidence from the local studies is that there is a shared understanding of respective responsibilities and goals. This is reflected in the joint strategies and plans which are now in place throughout the country and which provide general agreement on the scale of changes envisaged over the next two to three years.

After some initial resistance, health boards have signed up to the principle that the considerable resources locked up in long-stay hospitals should be channelled into social work services and are now working together - some more enthusiastically than others - to achieve that end.

"we found no evidence of NHS funds being misapplied by local authorities"

For their part, social works staff are having little difficulty in identifying replacement services which need to be put in place and which they consider suitable for resource transfer. A key outcome of the local studies is that we found no evidence of NHS funds being misapplied by local authorities.

Implementing changes in community services

Agreeing transfers of responsibility is a complex process, often involving lengthy preparatory work before changes in community services can be put in place. Progress on implementation may also be affected where partner agencies cannot afford to move on all fronts simultaneously.

The Scottish Office has issued detailed guidance to health boards and local authorities emphasising the importance of co-ordination in both the planning and provision of community services. It is worth mentioning that agreement on the former does not translate automatically into action on the latter, and auditors' reports highlight a number of examples of delays and difficulties in implementing planned objectives. Several common factors were identified:

Openness and communication

Resource transfer depends on trusts and boards identifying appropriate reductions in NHS provision and calculating the savings thus generated to finance replacement services within the community.

We noted marked differences between health boards in the extent to which they are prepared to take local authorities into their confidence and involve them directly in implementing changes. For example, some boards had invited their social work partners to take part in joint exercises to identify and assess changes in hospital provision, while others guard their role in undertaking these tasks independently.

The effect in the latter case is to stoke up suspicion among some local authorities that they are short-changed, by being given incomplete information on bed closures and on the true extent of savings realised. Where this is happening, local councils may be less committed to meeting their responsibility to invest in alternative facilities.

Local agreements

Health boards and local authorities need to reach agreement not just on objectives and plans, but also on how new services financed from resource transfers will be delivered and by whom. For the most part, this is achieved through formal 'contracts' which specify the amount of resources being released and how they will be spent.

We found evidence that the tasks of drawing up and agreeing specifications have led to delays in the implementation programme, as points of detail are argued back and forth. In some cases, where the savings have already been realised, health boards have transferred funds before agreements are properly in place. In other cases, agreements have been signed which omit key aspects of the transfer process.

Accountability

Without doubt, the question of how boards continue to exercise control over funds once they are handed over to local authorities has acted as a major constraint on the flow of transfer resources.

The problem is related to how the funds are used. Where local authorities are procuring services from a third party (eg for residential care), accounting for that expenditure is relatively straightforward. But the funds may well be intended to supplement existing budgets for services which the local authority itself provides, such as home helps.

There is a genuine difficulty here in identifying replacement services separately from routine expenditure by the social work department. The pressure to define practical accountability criteria in such circumstances has been a continuing source of concern and of conflict between health board and social work staff.

The evidence from our study is that none of these problems is insurmountable. Indeed some boards and authorities have already developed solutions which are being implemented successfully, and this report highlights particular examples of good practice.

Obstacles to change

Some of the obstacles to progress are as much philosophical as practical. On one side of the negotiating table, health boards view the people earmarked for transfer to the community as their 'patients' and are naturally cautious about handing over responsibility too easily.

On the other side, social work departments may feel that they have nothing to prove given their long experience of managing care in the community. There is a fine line between due caution and procrastination, and it is not surprising that the detailed vetting of community care projects by boards can sometimes lead to accusations of stalling tactics where resources are not being released as quickly as local authorities would like.

"there has to be mutual trust and a readiness to compromise in the interests of addressing the needs of the people requiring care."

Where it exists, such division can get in the way of effective implementation of agreed priorities and plans. Inevitably, boards and local authorities will survey the community scene from different perspectives; but for resource transfer to operate as intended, there has to be mutual trust and goodwill, and a readiness to compromise in the interests of addressing the needs of the people requiring care, while bearing in mind the need for proper accountability for the use of resources.

To a greater or lesser degree, boards and local authorities are developing better understanding and closer links with each other, and with other agencies, for example through the creation of liaison committees representing the interests of the different care groups. On a procedural level, there is an increasing use of protocols and formulae for cost savings aimed at simplifying the negotiation process and avoiding potential conflict and delay.

Data analysis

All of the these measures have contributed to the virtual doubling of resource transfer between 1994/95 and 1995/96, with a further increase projected for the current year. Analysis of data collected in the course of the study shows that the improvement is not consistent across the country, with significant variation in the progress achieved by individual boards and authorities.

These variations extend also to the level of transfers by care group, with marked differences in performance even within the same board and authority. As one might expect, progress has been greater where the process is more straightforward and easier to manage: thus transfers of patients from NHS beds into residential care account for around half of the resources released nationally. Conversely, it is generally taking longer to agree arrangements designed to avoid hospital admission, or to settle complex issues of accountability, as in the provision of domiciliary services.

Accountability guidelines

Other than a statement that health board general managers remain responsible for resources transferred, The Scottish Office have not set detailed criteria on how the accountability objective should be met. Because of the various uses of resource transfer, we believe that accountability will be exercised in different ways; this report suggests guidelines based on current good practice. We hope these will be helpful to boards and authorities which have experienced difficulties in developing appropriate arrangements themselves.

"Accountability is likely to remain a thorny issue for as long as the resource transfer scheme continues to operate."

Accountability is however likely to remain a thorny issue for as long as the resource transfer scheme continues to operate. While the link between specific NHS bed closures and replacement community services may be explicit at the time of transfer, it becomes less clear as patients die or their care needs change with the passing of time. And the more that individual resource transfer agreements are adapted to cater for such changes, the more difficult it is to enforce the original accountability arrangements.

Long-term options

This problem might be addressed by modifying the accountability requirements, perhaps restricting them to a limited period following transfer. A more radical solution would be to end resource transfer altogether and fund local authorities directly via appropriate adjustments to health board budgets.

The latter option is certainly in keeping with the spirit of the1990 Act which assigns lead responsibility for community care to local authorities. Thus, while health boards clearly have a strong interest in safeguarding the welfare of patients as they are discharged from hospital, it is councils which will cater for their

long-term needs. This will be decided, not by their status as ex-NHS patients, but in the context of providing a comprehensive service for all community care users. Against this background, the logic of continuing to channel resources through health boards looks increasingly tenuous, the more so as the people who originally transferred out of hospital are replaced by new users with potentially different care needs.

The 1993 Circular stated that it is the intention, when the current arrangements for effecting change have stabilised, to transfer provision to local authorities through the public expenditure survey (PES) programme. Now that a solid foundation has been laid, through joint strategies and plans, for incorporating appropriate adjustments within the PES process, we believe that this is an opportune time to consider whether, and for how long, the resource transfer scheme should continue in its present form.

1. Background

Introduction

The policy of care in the community is designed to enable a range of vulnerable groups, including the elderly and people with mental illness and learning disability, to live as normally as possible at home or in homely settings. This is being achieved by shifting the balance of care from hospitals, by reducing reliance on traditional long-stay institutions, and by avoiding admission to hospital where appropriate.

The NHS and Community Care Act 1990 gave local authorities the lead responsibility for planning and co-ordinating the provision of community care services within their area. To assist this process, Scottish Office guidance provides for the transfer of resources from health boards to local authorities. Resource transfer is intended to help pay for social care services required to resettle discharged patients in the community and to provide an alternative to hospital provision.

The fact that local authorities have the lead role in providing care in the community does not mean that they have sole responsibility. Many individuals will continue to have need of community health services provided both by general practitioners and by community trusts. In determining the proportion of savings from hospital bed closures which may be transferred to local authorities, the Management Executive have urged health boards to ensure that they allow for appropriate re-investment in community health and primary care services.

Exhibit 3: Shifting the balance of care

The aim of current policy is to secure:

- better match between social care needs and services
- significant reduction in long-stay hospital beds
- corresponding growth in community places
- increased range and volume of community services
- fewer admissions of elderly people to hospital
- better use of resources.

Source: Scottish Office guidance

Resource transfer scheme

While the present policy has its origins in the 1990 Act, the first resource transfers did not occur until three years later. The NHS Management Executive announced details of the scheme in a 1992 Circular which set out the financial framework to be followed by health boards and local authorities.

The early response to this initiative was disappointing. Cash transfers amounted to just £8 million for the whole of Scotland in 1993/94, with four boards contributing nothing at all to the overall total. To encourage co-operation, the Management Executive decided to offer inducements to boards through what became known colloquially as the 'pain and gain' scheme.

The scheme operated on the assumption that health boards should be able to transfer amounts which equated to their weighted capitation share of the national transfer total. Boards which failed to meet their target share were penalised by having the shortfall deducted from their annual allocation; while boards which achieved proportionally higher levels of resource transfer were rewarded accordingly.

In support of these arrangements, the Management Executive introduced procedures in 1993 for monitoring the transfer of resources between individual health boards and local authorities (Appendix 1). By 1994/95 the level of the funds being released by boards had climbed to £25 million. This was supplemented by a further £8 million, representing the value of contracts with external care providers which boards had assigned to local authorities.

Having achieved its intended purpose, the Management Executive abolished the 'pain and gain' scheme at the end of 1995/96.

Accounts Commission study

The aim of the Commission's study was to examine the progress made in planning and implementing appropriate service changes, and to assess the arrangements in place to manage the transfer of resources. The study by the Commission's auditors covered every health board and local authority in Scotland. It took place during local government reorganisation, focusing on expenditure in 1995/96. Details of the auditors' findings have been made available to the appropriate successor authorities.

The study was based on:

- discussions with health board and social works staff involved in managing the transfer process
- a review of community care plans and local agreements
- analysis of data on costs, bed closures and the development of community services
- an assessment of the accounting and monitoring arrangements.

Individual reports have been made to each health board and local authority, incorporating an agreed action plan to take forward suggested improvements.

"there is a fair measure of consistency in the way boards and authorities are handling resource transfer…"

The audit reports confirm that there is a fair measure of consistency in the way boards and authorities are handling resource transfer. They have all established liaison groups to represent different user interests and to oversee the implementation of objectives in Joint Community Care Plans. The working relationships at officer level are good on the whole (after a poor start in some cases), as evidenced by the increasing number of local agreements covering resource transfers and their use. Model agreements have been widely developed to help ease the negotiating process.

but "…there are also weaknesses in the way some boards are controlling and monitoring the movement and use of funds "

Some problems still persist, however. For example, a few local authorities expressed concern to auditors about lack of information on bed closures and consequential under-resourcing of alternative community services. And there are still imbalances in the sums generated by resource transfer both between boards and between care groups. There are also weaknesses in the way some boards control and monitor the movement and use of funds.

The next three chapters summarise auditors' findings in the following areas:

- joint planning and agreement
- implementing change
- accountability.

2. Joint planning and agreement

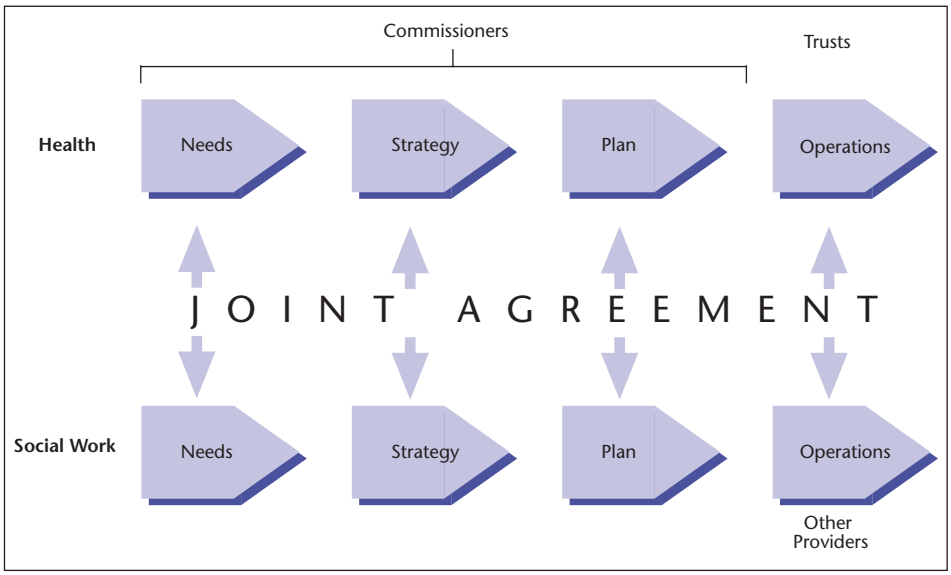
Relationships

The key to progress in implementing the community care reforms is a shared commitment and good relationships between health boards and local authorities. This principle also extends to other agencies and areas of mutual interest; but it is particularly relevant to developments taking place under the resource transfer scheme.

The Scottish Office guidance emphasises the importance of collaboration to ensure that the pace and scale of contraction within the NHS is matched by the development of alternative services in the community. This is required not just at the point of delivery but applies also to the planning and assessment of care needs. Nor is it simply a two-way process involving health boards and local authorities, but must embrace other key agencies, such as housing authorities and trusts.

Exhibit 4: Shared commitment and collaboration

Agreement must be reached at all stages with commissioners and providers.



Joint planning

Joint planning is undertaken by a hierarchy of liaison groups covering each of the key stages illustrated in exhibit 4. They generally include planning groups, which collaborate on strategy and policy, and development groups responsible for monitoring agreed priorities. A typical structure is given below.

Exhibit 5: Joint liaison structure

Joint Liaison Committee *(Members)*	Deals with the policy aspects of joint planning and oversees implementation. As well as the health board and local authority, may include representatives from specific voluntary agencies.
Joint Planning Executive *(Chief Officers)*	Identifies strategic initiatives for services and monitors progress. Represents main commissioning agencies, including housing bodies.
Strategic Planning Groups *(Officers)*	Develops and oversees delivery of the planning agenda. Organised by care group with representatives from relevant agencies, including independent sector.
Service Development Groups (*Service Managers and Staff)*	Multi-agency and multi-disciplinary groups responsible for progressing the priorities agreed by the appropriate Strategic Planning Groups.

Source: auditor's reports

The framework for joint planning is designed to ensure that, at the top, members and chief officers of the health board and local authority have the necessary information to agree policy matters where there is both a health and social services responsibility.

The joint community care plan is the main vehicle for formalising agreement at this level. Plans cover a three-year period and are reviewed and rolled forward annually. Within the overall strategy, they should incorporate discrete objectives and targets for each care group, relating to:

- proposed development of services and accomodation, including housing.
- timescale for completion
- commitment of resources
- responsibility for implemention.

The main thrust of The Scottish Office's guidance is that boards and local authorities should not operate in isolation in undertaking service planning. Instead they need to work closely together, as well as with other agencies, if the current policy on care in the community is to be developed properly.

Early direct involvement is the key, starting from joint assessment of need and proceeding through extensive consultation on the production of the plan itself. Working closely together in this way should encourage openness and a shared commitment to act in the interests of all commissioners and users of services.

The evidence from local studies is that health boards and local authorities are recognising the importance of collaboration in implementing essential changes in community services and making the best use of finite joint resources. Most of the board and social work staff to whom auditors spoke commented that relationships have improved in recent years through regular contact and communication.

Exhibit 6: Examples of openness and collaboration

- External agencies, including housing, voluntary and private sector bodies, well represented on appropriate liaison groups.
- Joint community care plan incorporates discrete strategies and objectives for each care group.
- Meetings of liaison groups arranged according to a pre-determined cycle (eg monthly, quarterly) which reflects their respective responsibilities.
- Joint reviews undertaken of long-stay hospital beds to establish a common understanding of current levels of provision and scope for reductions.
- In support of plans, agreement reached on a set of formal principles to be applied to areas of joint responsibility, such as assessment, funding arrangements, and commissioning and contracting procedures.
- One board and council founded a joint commissioning agency consisting of a senior officer from each body working together on a full-time basis in managing developments and priorities.

Source: auditors' reports

Where arrangements are not working well, it has generally been attributed to human failing rather than weaknesses in systems. Auditors' reports noted that some groups lacked clear purpose and that there were inconsistencies between groups regarding membership and responsibilities. In two separate instances, health board and council staff literally stopped speaking to each other because of disagreements over the way services might be developed. This led to a complete breakdown in communication for a period of several months.

Over-emphasis on the planning regime drew criticism from some auditors who expressed concern in their reports about the absence of a parallel structure to monitor progress in implementing agreed priorities. Better feedback on such progress might help in the setting of more realistic targets and make more efficient use of staff time.

Resource transfer agreements

The importance of co-ordination and collaboration means that resource transfer fits well into the overall planning framework. Proposed developments under the resource transfer scheme should be incorporated in joint community care plans. This will usually be supplemented with a discrete strategy, reflecting the distinctive nature of the resource transfer arrangements.

The strategy represents the health board's plans for achieving a shift away from hospital to community services, based on consultation with trusts, social work, housing and other relevant agencies. Ideally, it should set out the policy and approach for each client group, and identify

- the priorities for change within each group
- the anticipated level of resources transferring from the health board
- the alternative care services to be funded by local authorities using transfer resources, including the involvement of housing and other agencies.

Having established an agenda, the final stage in the process of implementing agreed changes is the resource transfer agreement which serves as a contract between the health board and local authority. There is no standard format but, typically, separate agreements are negotiated for each project (or group of related projects) specifying the available funding, how it is to be spent, and the conditions attaching to its use.

"the local agreement is the mechanism by which real shifts in the boundaries between health and social care are achieved"

In effect, the local agreement is the mechanism by which real shifts in the boundaries between health and social care are achieved. It is also the stage at which friction is most likely to occur because of the sheer number of issues to be settled. The concern is not whether a particular group of people should be moved out of hospital into residential care or housing - on which there may be widespread consensus - but rather a host of practical considerations, such as when and over what timescale it should happen, and how it will be financed and accounted for.

Reports by auditors highlight a number of instances where protracted negotiation over the terms of local agreements has hindered progress in implementing planned changes. In some cases, this may be the result of genuine concern about service delivery: for example, where the amount of the transfer offered by the board falls short of the local authority's estimate of the investment required in new facilities.

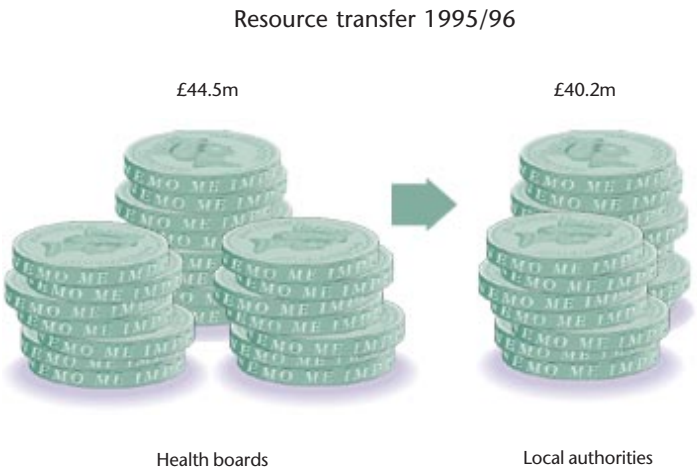
Very often, however, the conflict has more to do with the administrative than the operational arrangements. One of the most common causes of delay has been the failure to agree arrangements, to the satisfaction of health boards, for accounting for transferred resources by local authorities.

The effect of such division manifests itself in different ways. On a purely administrative level, it has resulted in funds being released by boards before terms are agreed and agreements signed. Ultimately, it may mean that community projects are delayed or do not start at all in the year in which they were planned.

An interesting feature of auditors' analysis of resource transfers is the gap between the figures for resources transferred by boards and for expenditure by local authorities (exhibit 7). This can be attributed in part to the knock-on effect of the failure to reach early agreement on the flow of resources earmarked for transfer in 1995/96. The result was a late surge of funds from boards, anxious to meet their financial targets, which local authorities were unable to spend until 1996/97.

Exhibit 7: Flow of transfer resources

Because of the timing of some transfers, there was a mismatch of £4.3m between advances by boards and the funds available to councils in 1995/96.



Source: auditors' reports

Our study suggests that problems are less likely to arise, and the flow of funds speeded up, where boards and local authorities are able to agree standard arrangements for resource transfer. Some now make use of model agreements which avoid the need for one-off negotiation of detailed terms and conditions (exhibit 8).

A few have gone further and agreed standard costings for bed closures by client group and type of care. One board and local authority are discussing a long-term agreement covering the provision of mental health services for a period of 10 years or until a permanent transfer of funds to the council is possible.

Exhibit 8: Model agreements for resource transfer

Model agreements help focus attention on the management of change by dispensing with the need for detailed discussion of contract terms and conditions.

Agreements should incorporate standard clauses covering:

- Use of transfer resources
- Approval of changes in use
- Transfer amounts
- Carry-forward funding
- Annual adjustment for inflation and efficiency savings
- Sub-contracts with providers
- Scheduling of payments
- Monitoring and review
- Provision of accounts
- Audit
- Resolution of disputes

Source: auditors' reports

3. Implementing change

Objectives

The availability of resource transfer provides essential financial incentives for shifting the balance of care from NHS hospitals to the community. The aim is to ensure that facilities and services are in place before patients are discharged from hospital - reinforcing the importance of consultation and agreement on the processes for implementing change.

The Government's intention is to achieve a significant reduction in inappropriate institutional care for each of the target care groups: geriatric, psychogeriatric, learning disability and mental illness. This is a continuation of a long-standing policy which has seen bed numbers fall by 8,000 (28%) in five years (exhibit 1) and envisages similar reductions in the years ahead, subject to joint assessment of needs.

While the objectives are broadly the same for each care group, in practice they are being met in different ways. For mental illness and learning disability, the emphasis is on transferring people currently catered for in hospital into community settings. On the other hand, the expectation is that very few psychogeriatric and frail elderly patients will be discharged from hospital. Rather, the policy is based on developing alternative services and facilities in the community, aimed at avoiding admission to hospital wherever possible.

A key element of the studies undertaken by auditors was a review of the generation, use and control of resources transferred by health boards to local authorities. Specific objectives were to:

- analyse and compare the amounts being transferred by individual boards and by care groups
- examine the correlation between changes in bed use and transferred resources
- assess the reasonableness of the sums being transferred
- review the arrangements for monitoring and accounting for the use of transfer resources.

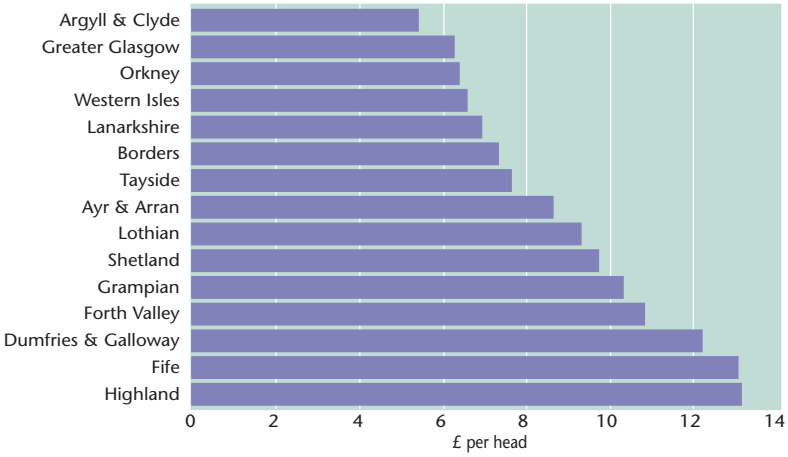
Analysis of transfer amounts

Details of the resources transferred in 1995/96 are given in Appendix 2. They show that there is considerable variation in the amounts released by individual health boards. This reflects in part the huge differences in the populations served by boards and in the respective budgets for community health services.

One way of overcoming differences of scale between health boards is to analyse resource transfer by head of population (exhibit 9). This shows considerable variation in the relative sums being released and supports the findings from local studies that some boards have been more successful than others in identifying opportunities for change and securing agreement with local authorities on the use of transfer resources.

Exhibit 9: Resource transfer per head of population

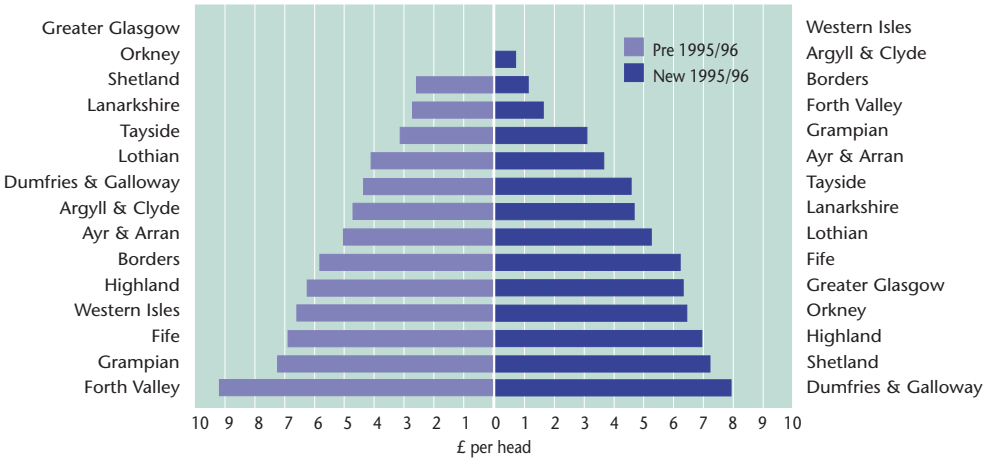
Resource transfers by individual health boards varied between £5.42 and £13.16 per head of population in 1995/96.



Sources: ISD population data 1995; auditors' reports

Cost per head is however a fairly crude measure and should not be interpreted too literally as a measure of current performance. It does not, for example, take account of differences in the complexity of transfer programmes, or the fact that some community plans concentrated initially on major closure projects which generally take longer to get off the ground and may realise only limited cash savings in the early stages.

Exhibit 10: Analysis of transfers by year of agreement



Source: auditor's report

The analysis at exhibit 10 shows that some boards, who were slow starters initially, are now performing much better based on the level of new funds transferred in 1995/96.

Care groups

As noted in the previous chapter, collaboration between boards and local authorities is also a powerful influence in promoting and progressing change. This may well vary within as well as between bodies, often reflecting the effectiveness of the liaison arrangements for the different care groups. In this connection, auditors' reports comment on marked differences in the sophistication of the detailed strategy for particular care groups which have clearly had a bearing on the distribution of resource transfer funds.

Exhibit 11: Resource transfers by care group

Group	Beds		Resources	
	Number	%	£'000	%
Mental Illness	5018	24.0	9422	21.2
Learning Disability	3400	16.3	17457	39.2
Geriatric	6790	32.5	11594	26.0
Psychogeriatric	5688	27.2	2879	6.5
Other			3171	7.1
Total	**20896**	**100.0**	**44523**	**100.0**

Notes

1 Based on bed numbers at 31 March 1995 (exhibit 1).

2 'Other' includes hybrid projects which do not fit into one particular group.

Source: ISD/auditors reports

The table illustrates the imbalance between the top two groups, where the programme of change is mainly being driven by moving patients out of hospital into the community (accounting for 60% of resources against 40% of beds), and the next two, where the emphasis is on avoiding hospital admission (32% of resources against 60% of beds).

Once again, this assessment is supported by evidence from local studies that projects in the latter category are not linked so closely to, or so easily financed by, specific bed closures. According to the detailed data collected by auditors, more than half the boards had transferred nothing at all towards services in one of the two elderly care groups for the period up to March 1996.

Exhibit 12: A 'typical' resource transfer pound

Source: auditors' report

Further analysis of resource transfers by project type confirms that roughly 50 pence in every pound of expenditure involves a bed closure and an investment in some form of residential care (exhibit 12). Only a very small proportion comes from reducing hospital admission although that contribution may grow as more schemes are targeted by boards and local authorities in future plans.

Changes in bed use

The current policy is intended to ensure that, as responsibility for service provision moves from health boards to local authorities, resources should shift also. Where appropriate, health boards should retain an element to cover essential re-investment in the continuing health care needs of people transferring to the community: for example in coping with any additional demand which may fall on community health services or general practitioners.

That aside, the dominant factor in calculating the transfer sum is the saving to the NHS budget - and not the cost of alternative care. Boards do of course have a duty under the accountability arrangements to ensure that funds are fully committed in providing appropriate community services (chapter 4).

These principles extend to the de-commissioning of major hospitals as well as to bed closures on a small scale. In some cases, resources will transfer as beds are closed; but in others there is a need to create new services first to prevent admissions.

The size and timing of payments are matters for negotiation between the health board and the local authority. Where the transfer is directly linked to bed closures, it should also involve consultation with the hospital trust since any savings will effectively be met from its budget.

The feedback from local studies suggests that there are three areas of potential conflict (exhibit 13):

- the true scale of bed closures, both past and present
- the calculation of the cash saving
- the amount retained by the board against continuing NHS commitments.

Bed numbers

The process of closing hospital beds and moving people into the community did not start with the present resource transfer scheme but has been gathering pace over a number of years in line with Government policy. One of the main reasons why resource transfer was slow to develop in some areas was confusion over the extent to which earlier changes should be taken into account in the calculation.

Some local authorities took the view that they should be recompensed where the effect of changes in treatment - in particular since the 1990 Act came into effect - had been to shift the financial burden and responsibility for the care of former NHS patients onto them. Most boards acknowledged the principle though some took longer than others to agree the contribution which they should make towards past events.

Several boards involved authorities directly in reviewing bed stocks as a basis for past and current cash settlements. Auditors noted however that, having done so, few followed this up with routine monitoring of on-going changes in bed use. As a result there continues to be confusion over numbers in some places, as evidenced by the perceptions of social work staff that they are not always informed about bed closures.

Exhibit 13: Negotiating resource transfer sums

Basis of conflict	Good practice
Bed numbers	
• lack of consensus on existing bed numbers	• agreement reached on 'opening' bed numbers each year • some local authorities invited to participate in joint audits of bed use at trusts
• failure to monitor changes in bed use at trusts	• agreements should provide for exchange of data • local authority given access to ISD data
• poor quality data	• trust contractually obliged to notify board of changes in bed use
• no advance notice of bed closures	• local authority should receive timely information on bed closures • consulted in advance on resource transfer implications
Costings	
• calculation treated as confidential between board and trust	• agreement on sum not essential, but important that methodology is explained to local authority • with agreement of authority, standard costings applied to particular closures to reduce the need for ad hoc calculations
• no detailed costings in support of calculation	• where possible, trust contract tariff should be used as the basis of the 'saving' arising from a bed closure or change in use • the breakdown of costs should be documented and available for inspection
• lack of clarity on level of on-going transfer	• agreements between board and authority provide for annual adjustment in respect of inflation and efficiency gains
Retention of NHS element	
• arbitrary adjustment made for continuing NHS commitments	• board should justify any deductions from 'contract' saving
• lack of consultation with local authority	• adjustments should be consistently applied from one project to another • where possible, standard gross and net tariffs should be agreed by type of bed

Source: auditors reports

There is also evidence that boards may not be fully aware of local decisions on changes in bed use, and some have now made such disclosure a condition of their contract with the trust. Where appropriate, auditors have emphasised in local action plans the need for full disclosure on all sides, and for regular joint review of bed data.

Calculating resource transfer

The value placed on the resource transfer element of a change in service provision is a matter of negotiation between the health board and the local authority. Where the transfer relates to bed closures, it will also involve negotiation with the hospital trust since the resources are effectively being diverted from its budget to the local authority.

There is considerable variation in the rate of transfer payments per bed closure. From a sample of seven health boards, the average rate ranged from £4,000 up to £32,000 per bed for payments made in 1995/96.

The reason for such variation is that the rate depends on a number of factors, such as the type of bed and the scale of the closure. For example, changing the use of a few beds in a ward might offer up only marginal savings because the major element of the overhead costs will continue to be borne by the trust. By contrast, the closure of an entire hospital or ward generally means that resource transfer will more closely reflect the gross reduction in costs.

The fact that the payment rate varies so much is undoubtedly a major source of friction between boards and local authorities. This is not helped by the (misguided) belief of some social work staff that resource transfer is intended to cover, instead of merely contribute to, the cost of replacement services. There is confusion also over the right of boards to retain an element for re-investment in the continuing health care needs of transferring patients.

Some boards have not helped matters by undue secrecy about the basis of resource transfer amounts. Auditors encountered problems too in reviewing the calculations. While there were no reports of deliberate under-recording of savings, in some cases auditors were unable to check the figures in detail because of a lack of documentation in support of calculations made by health board staff.

There is evidence that boards are becoming more sensitive to the difficulties faced by local authorities in budgeting for replacement costs against wild fluctuations in the resource transfer rate. One way to minimise such changes, and at the same time avoid the constant round of case-by-case negotiations, is to agree a tariff or 'dowry', based on average savings, which will apply to all closures over a period of time.

A few boards are now moving in this direction in consultation with their local authority partners. As with all such developments, progress depends on good faith and openness on the key elements of costs and service delivery which will form the basis of any agreements between them.

4. Accountability

An interim measure

Under the current policy, health board general managers remain accountable for local authorities' use of transferred resources. The Scottish Office guidance states that this is a temporary measure only: the ultimate objective, once the process of readjusting traditional care boundaries has stabilised, is to alter the present arrangements so that local authorities can be funded directly for these services acquired from the public expenditure programme.

The effect of the accountability arrangements is that boards have a continuing responsibility to ensure that transfer resources are being put to proper use. This entails regular monitoring by boards of local authority expenditure on approved projects. Resource transfer agreements should therefore include provision for access to local authority records and the submission of accounts.

Issues from studies

In their review of local agreements, auditors found that compliance with accountability arrangements was at best patchy and in some cases practically non-existent. Essentially there were two main areas of weakness:

- a lack of clarity within some agreements about the precise nature and object of the accounting arrangements
- a failure to invoke agreements, resulting in late or incomplete submission and review of accounts.

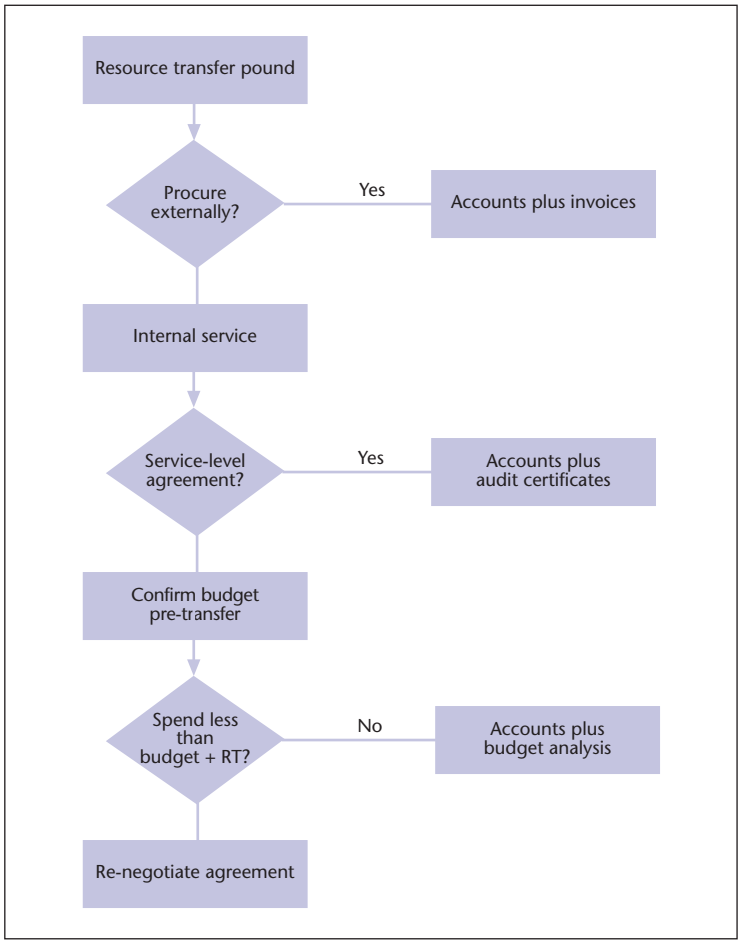
These two issues represent opposite sides of the same coin. They both stem from a basic uncertainty about the best way of accounting for the full range of services for which resource transfer is available: in particular, how to apply accountability criteria to those services which local authorities provide already under existing programmes. The difficulty here lies in distinguishing the resource transfer element - for example in employing home helps - from routine expenditure within the social services budget.

Auditors found that agreements often incorporate only very general provisions, specifying perhaps that accounts of expenditure will be submitted with supporting vouchers under a given timescale. This can work reasonably well where the local authority is procuring a service from an external source as, say, for residential care; but it may not be appropriate, or enforceable, in other circumstances.

What is needed is a flexible approach which recognises that accounting requirements - and more importantly accountability standards - will necessarily vary according to the type of service being procured through resource transfer (exhibit 14).

Exhibit 14: Accounting arrangements

Different arrangements are likely to be required depending on the use of transferred resources.



A few boards have started to develop systems for tracking the use of transfer resources on internal services against adjustments to base level budgets. Internal audit is being used in other cases to substantiate expenditure on separately managed operations, such as local authority care homes. This is by no means an exhaustive list, but it does illustrate the importance of tailoring accountability arrangements appropriately.

On-going arrangements

There is a fundamental issue regarding the practicality of the accountability arrangements in the longer-term. Several boards and local authorities expressed concern to auditors about the increasing difficulty in applying meaningful criteria, and criticised the lack of detailed guidelines on methodology and standards. The fact that accountability requirements are being widely ignored says much about staff attitudes on both sides of the resource transfer process.

It is worth emphasising that the concern is about procedures and not the misuse of funds, of which there is no evidence in auditors' reports. There is an effectiveness issue, however, with the progress of some projects being hampered by the failure to agree or implement appropriate accountability arrangements.

In one case, a health board refused to make further payments to a local authority during 1995/96 because of the absence of proper accounts. While this reaction was exceptional, several boards admitted to feeling uneasy about their continuing responsibility for the oversight of transfer funds, and used the issue to justify a cautious approach in implementing agreed changes in community plans.

Despite the development of new techniques, it is likely that the difficulty in exercising control will become greater rather than diminish in the years to come. This view is based on a broader mix of agreements in place and the cumulative nature of resource transfer. The result is that future accountability arrangements will have to cater for a whole range of budget and other adjustments, making the task of tracking expenditure increasingly complex and requiring ever more sophisticated forms of account.

As this happens, the case grows stronger for making local authorities directly accountable for maintaining and developing services for former NHS patients, as envisaged when the resource transfer scheme was introduced. Not only would this resolve the accountability issue, in our view it would help speed up the movement of resources in line with joint community plans.

The essential ingredients for amending the funding arrangements are in place already through the strategy and objectives detailed in joint community plans. These could be used as the basis for agreeing the local programmes of service changes and consequential adjustments to NHS and local authority budgets. In turn, this would remove the need to negotiate separate agreements for individual projects and, with it, one of the main obstacles in progressing planned objectives under the present regime.

5. Towards the Millennium

General

The 1990s have seen a revolution in the way community care is administered in Scotland. Social work authorities now command a much greater share of the community care budget and with it the lead responsibility for procuring local services.

A measure of the shift in the boundary between hospital and community services is the substantial increase in funds available to local councils from resource transfer and other sources. And this reinvestment will continue to rise during the next few years as the balance tilts further towards care in the community.

Organisational changes

The changes in the resourcing of community care have been accompanied by far-reaching reforms within local government and the NHS. In the latter case, this has led to the separation of responsibility for commissioning and providing care though the establishment of NHS trusts catering for local community health needs under contract to health boards.

The NHS reforms were followed by local government reorganisation on 1 April 1996 which saw the 12 regional and islands councils replaced by 32 local councils.

The inevitable consequence of these reforms is to make the process of consultation and agreement on operational changes more complex and potentially more protracted. Where before a health board might expect to deal directly with a single local authority on a proposal to transfer patients out of hospital to the community, it may now have to negotiate with several councils, as well as the management of the hospital trust. And this is before it consults with any voluntary, housing or other agencies which may have an interest.

By way of compensation, the NHS and Community Care Act 1990 and subsequent guidance have given much clearer direction on the objectives, priorities and respective responsibilities for community care. The thrust of the current policy is to shift influence away from discrete, fragmented care provision towards co-ordinated services designed to address the wider needs of users and their carers. Hence the emphasis on joint planning and collaboration in effecting changes.

One consequence of the increase in the number of local councils is that it will add considerably to the monitoring burden imposed on health boards under the present policy on resource transfer, and stretch still further lines of accountability as the new councils assume responsibility for agreements reached by their predecessor authorities. This is yet another factor to be taken into account in any review of the current funding arrangements.

Enquiry by the Scottish Affairs Committee

The Scottish Affairs Committee has been looking into the implementation and resourcing of community care in Scotland. It recently published a Second Report on its enquiries, which included evidence presented by the Accounts Commission on the preliminary findings from our review.

The Committee's Report highlights the importance of sufficient, well-channelled resources in implementing community care policy and in meeting the needs of users. It suggests however that progress has been hampered in some areas by inefficient use of resources and by confusion over the level of available funds.

On resource transfer, the Report registered the Committee's concern over evidence presented to them of poor relationships between some health boards and local authorities, and of serious disagreements about the true level and proper resourcing of service changes. The Committee expressed the view that some social work authorities have been financially disadvantaged as a result, and warned that this will continue to be the case until perceived weaknesses in the resource transfer arrangements are remedied.

The Committee endorsed the general line taken by the Accounts Commission's auditors in local reports of encouraging health boards and local authorities to match the progress in negotiating transfers of lead responsibility for services, and to meet the standards on collaboration and control, which are being achieved already by the best performers.

The Accounts Commission's role

The Accounts Commission intends to continue the process of promoting change by identifying best practice, and helping health and local authorities to meet policy objectives for community care and make efficient use of resources.

The resource transfer study was the first of a series which will review the implementation of community care. The next report is planned for autumn 1997 and will examine how the new local authorities are developing their lead role in commissioning care services.

Future studies will look at the quality of service delivery as well as cost. To this end, auditors are currently undertaking a review of adult mental health services. This work is being phased over two years and focuses initially on the role of community trusts.

The second phase of the study will examine the effectiveness of inter-agency working in the provision and planning of adult mental health services, and will also cover commissioning by health boards and local authorities. Comparative data will be collected on the targeting of resources by trusts and social work authorities, and on the staffing of social work services.

It is intended that this work will contribute to the development of the national handbook on commissioning practices. A national report will be published in 1998 covering the Commission's review of adult mental services in Scotland.

Building on this work and the results of the general research by the Health and Social Work Directorate, further studies will be developed in consultation with health and local authorities, as well as other parties with an interest in community care.

Appendix 1

Scottish Office Circulars

Planning

SWSG1/91	Community Care in Scotland: Community Care Planning
SWSG4/93	Community Care Plans: Directions on Consultation
SWSG7/94	Community Care: The Housing Dimension
SWSG14/94	Community Care Planning

Policy

SWSG 1/92	Community Care: Guidance on Care Programmes for People with a Mental Illness,
SWSG102/94	Continuing Care of the Frail Elderly

Funding

SWSG10/90	NHS and Community Care Act 1990: Specific Grant for Revenue Expenditure on New Community Projects in the Mental Illness Field
MEL(1992)55	Community Care: Joint Purchasing, Resource Transfer and Contracting: Arrangements for Inter-agency Working
MEL(1993)67	Community Care in Scotland: 1993/94 Bridging Finance Scheme
FIN(GEN)1993/4	Community Care: Resource Transfer
SW9/1994	NHS and Community Care Act 1990: Mental Illness Specific Revenue Grant (MISG)

Appendix 2

Resource transfers: from NHS

Health Board	Pre-95/96 £'000	New 95/96 £'000	Total 95/96 £'000
Argyll & Clyde	2040	308	2348
Ayr & Arran	1888	1373	3261
Borders	616	120	736
Dumfries & Galloway	644	1165	1809
Fife	2429	2174	4603
Forth Valley	2524	447	2971
Grampian	3866	1641	5507
Greater Glasgow		5730	5730
Highland	1301	1436	2737
Lanarkshire	1513	2606	4119
Lothian	3138	3990	7128
Orkney		128	128
Shetland	59	165	224
Tayside	1230	1801	3031
Western Isles	191		191
Total	**21439**	**23084**	**44523**

Appendix 3

Resource transfer: to local authorities

Regional/Islands Council	Total 95/96 £'000
Borders	736
Central	2964
Dumfries & Galloway	1165
Fife	3599
Grampian	5407
Highland	2737
Lothian	7128
Orkney	77
Shetland	224
Strathclyde	14213
Tayside	1801
Western Isles	176
Total	**40227**

18 George Street
Edinburgh EH2 2QU
Telephone 0131 477 1234
http://www.scot-ac.gov.uk
ISBN 0906206 40 5