The Scottish Government

Evaluation of Integrated Resource Framework Test Sites

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EVALUATION OF INTEGRATED RESOURCE FRAMEWORK TEST SITES

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1 EXECUTIVE SUMMARY

1.1 This report presents a summary of the main findings of the evaluation of the development and implementation of the Integrated Resource Framework (IRF) in four test site areas in Scotland. The study was commissioned by the Scottish Government in March 2010 and undertaken by Fortuno Consulting and Partners. The IRF is a mechanism developed by the Scottish Government and partners to support shifts in the balance of care through integrated mapping information for health and social care and new joint financial mechanisms between Local Authorities and NHS Boards. The IRF aims to help health and social care partners to undertake integrated data mapping to understand more clearly current resource use across health and social care, enabling better local understanding of costs, activity and variation across service planning and provision for different population groups.

Main Findings

- For the first time partners in the IRF test sites attempted to map cost and activity data across health and social care. Analysis of this data started to improve the evidence base on which planning decisions are made.
- The IRF test sites used the mapping data to examine equity, efficiency, variation and quality but encountered difficulties in engaging GPs and hospital clinicians in discussion of the data, and also in linking outcome data into the analysis.
- IRF test sites worked with national support to improve the detail and accuracy of joint cost and activity information for health and social care. NHS hospital data on cost and activity is centrally gathered and well developed. Work remains ongoing to address the data protection and standardisation issues which limit the extent to which social care and community care costs can be accurately presented at detailed patient level.
- The IRF enabled senior managers in NHS Boards and Local Authorities to coordinate joint working and empowered health and social care staff to reflect on how to work together to improve care pathways and care provision for local populations.
- The success of new ways of integrated working was linked to the extent to which relevant stakeholders were: represented in planning structures; incentivised to engage in analysis of data; and empowered to influence planning decisions.
- Within the timescale of the evaluation, the IRF did not provide evidence of integrated work resulting in the release of resources or of significant changes to fixed costs.
- Integration of health and social care requires clarity of purpose and outcomes. The benefits of integration must be agreed and the evidence base for this strengthened. Strong leadership commitment should be matched with an informed empowerment of staff, patients and carers.
- Integration of health and social care requires commitment to an appropriate scale and scope. Careful consideration needs to be given to which services should be integrated and the timescale over which integration should take place.
- Integration of health and social care requires alignment of all available drivers - policy, legislation, structures, information, incentives, and outcomes - to create momentum for change.

What is the IRF?

1.2 The IRF has been developed jointly by the Scottish Government, NHS Scotland and Convention of Scottish Local Authorities (COSLA) to enable partners in NHS Scotland and Local Authorities to be clearer about the cost and quality implications of local decision-making about health and social care. The IRF aims to help partnerships to understand more clearly current resource use across health and social care, enabling better local understanding of costs, activity and variation across service planning and provision for different population groups

1.3 Two broad areas of work have been pursued under IRF: (i) Explicit mapping of cost and activity information for health and adult social care to provide a detailed understanding of existing resource profiles for Partnership populations; and (ii) Work by NHS Board and Local Authority partners in test sites to develop protocols that describe agreed and transparent methods to allow this resource to flow between partners.

1.4 Applications from NHS Boards and their Local Authority partners to participate as test sites in the IRF resulted in the selection of test sites in four NHS Boards and twelve Local Authorities in Ayrshire and Arran, Highland, Lothian and Tayside. These sites received £400,000 between 2010 and 2012 for mapping work, organisational development, and project management.

Evaluation aims and methods

1.5 The overall aims of the evaluation were to: monitor progress in the test sites; assess the impact of the work of the test sites; feed evidence back into the process of change itself; and draw out implications from the findings for other partnerships moving towards financial and resource integration, both within and across, health and adult social care services in Scotland in the future.

1.6 The evaluation took place in three phases between April 2010 and March 2012 and used five main methodologies to gather information: review of IRF documentation in test sites; reviewing processes and discussions at IRF Project Team and Programme Board meetings; interviews with key strategic partners; an email survey of delivery staff at each test site (carried out just after the baseline phase and repeated at the final phase of the evaluation); focus groups with operational (patient and client facing) staff.

Findings

Joint mapping of cost and activity

1.7 There has been progress in mapping health and social care data. All test sites mapped cost and activity across health and social care. It was reported that this was the first time that mapping information across the partners had been undertaken and that this was helpful in building a more complete picture of activity patterns and the associated costs. Flexibility to design local

approaches to mapping enabled this to best fit the expectations and uses of each test site. However, it also made broader comparison more difficult.

1.8 A large proportion of hospital costs can be mapped at an individual level using centrally collected Scottish Morbidity Record (SMR) and prescribing data. However, detailed information on community health and social care costs is not yet standardised or centrally collected, raising questions of credibility and confidence in how data are produced and applied.

1.9 Mapping at a patient level has raised significant data protection challenges. In order to address this, Local Authorities, NHS Boards, and GP practices require clarity on the use to which such data will be put, and the steps which will be taken to ensure anonymity and confidentiality. The IRF cost and activity data did not include public health activity, which was reported to have a substantial effect on demand into the system.

1.10 The IRF mapping information was used to facilitate more open and transparent discussion of integrated working across health and social care. Test sites attempted to use the mapping to look at unwarranted variation, identify potential service improvements and examine how services could be provided more efficiently. The potential of the mapping data to help define, measure and monitor outcomes was recognised but remains underdeveloped.

1.11 Staff involved in Community Health Partnerships (CHPs), locality planning groups, or IRF steering groups, have a responsibility to plan, organise and manage services in an efficient, effective, and equitable way. Consequently, information to support partnership working and integrated service planning was of obvious and immediate value to this group of stakeholders.

1.12 Engaging with wider staff groups whose main role was direct delivery of care (GPs, hospital clinicians, social care managers etc.) proved difficult. The immediate demands of caring for the current needs of patients and service users make it more difficult to find time to step back and look at the impact on planning future services. The IRF programme was designed with engagement of GPs and clinicians at its core. However, the experiences reported by the test sites indicated that local partners did not make a clear enough case for affecting the work of these individuals nor how these individuals can affect the outcomes.

1.13 While some of the mapping data is recorded in public record, and therefore in the public domain, there is greater potential to interrogate and then share the mapping data with service users, or more generally with the public.

Trialling new models of integration

1.14 Progress with trialling new models of integrated working was linked to existing knowledge of the services and of realistic appraisal of the extent of partnership. Test sites reported the importance of balancing the funding level and timescale alongside local drivers and barriers in order to define realistic opportunities for better integrated working. Test sites made more progress when they took a pragmatic approach to integration by building on existing

local knowledge and relationships. These sites restricted their scope to a manageable geography, population, number of service partners and ambition of impact. An alternative approach taken in Highland indicated that more ambitious change could be introduced where local leadership was willing to extend the timeframe for implementing change.

1.15 The test sites did not implement new financial mechanisms within the expected IRF timeframe. However, during the IRF pilot phase, the Highland Partnership took a decision to bypass the process of trialling small scale pilots of change as a means to testing out the potential of integration. Instead a commitment was made to full scale implementation of new financial mechanisms and governance arrangements using a Lead Agency model.

1.16 The IRF test sites found it difficult to get meaningful representation or engagement with groups such as GPs or hospital clinicians. There are four key factors which could be used to incentivise greater engagement with delivery staff: patient outcomes; professional standing; financial reward; and workload balance. Where these were present and recognised then engagement in service change was more likely.

1.17 The IRF raised partners' awareness of variation in activity and in costs. However, it also brought into sharper focus the difficulties of improving efficiency and addressing unwanted variation when there is no direct financial mechanism to link demand and supply across the health and social care system.

1.18 The IRF helped to support the case for shifting the balance of care by continually highlighting the idea of opportunity cost in discussions on the best use of resources. However, there was a lack of evidence that the IRF has influenced transfer of resources, and fixed costs remain a significant challenge.

1.19 The commitment at a strategic leadership level from Chief Executives in NHS Boards and in Local Authorities was important where large scale integration was considered. Non-partisan support from elected members was also reported to be valuable and worthy of investment.

1.20 The test sites recognised the importance of networks and relationships in creating a natural momentum for integration. When introducing new models of working the test sites encountered a number of barriers and used strong relationships and a shared commitment to create solutions or work around these problems.

1.21 The test sites reported the value of work amongst partners to articulate and understand the shared aims and outcomes that gave purpose to integration. It was acknowledged that variation in perceptions of risk could undermine this.

Conclusion

1.22 The IRF enabled four NHS Boards and 12 Local Authorities to gain a clearer understanding of health and social care costs and activity. It has identified

some of the limitations of current data, but also started to address some of these through national support of local innovation. It encouraged partners to experiment with new ways of jointly planning services and delivering care. Over the past two years, it has supported national policy direction to shift the balance of care and has contributed to the development of a growing culture of more integrated service delivery. Implementation of new financial mechanisms to integrate resources proved a lengthier undertaking than expected, and the full value of new financial models has yet to be tested in Scotland.

1.23 The evaluation of the IRF has shown the importance of: jointly defining the purpose of integration; ensuring sufficient scope, scale and time for integrating services; and harnessing all available drivers to encourage strong leadership, engage stakeholders and deliver change. This learning should inform further development of the IRF and may well be relevant in the consideration of emerging policy and legislation about the future integration of health and social care services.

Recommendations

1.24 The full report outlines 11 recommendations which focus on: (i) clearly communicating the purpose of and commitment to integrated working; (ii) reviewing planning structures to incentivise engagement, improve representation, and ensure that those planning services have the necessary skills to interpret data and negotiate decisions; (iii) continuing to address the limitations in the data and share good practice on how this can be used; and (iv) examining the definition of fixed costs and exploring ways of releasing/transferring cost savings.

2 INTRODUCTION

2.1 This report presents the findings of the evaluation of the development and implementation of the Integrated Resource Framework (IRF) in four test site areas in Scotland. The study was commissioned by the Scottish Government in March 2010 to be undertaken by Fortuno Consulting and Partners. It builds on the findings of the baseline and interim phases of the evaluation, which were shared with test sites in October 2010 and June 2011.

What is the IRF?

2.2 The IRF was designed to enable partners involved in planning and delivering health and social care services to ask two related questions: "How do we currently spend the money that we have available?" and "Is there a better way to do this?" It aimed to inform partners of the current distribution of their resources in order to enable them to make better informed and equitable resource investment decisions and secure improved outcomes for individuals and communities.

2.3 In order to achieve these aims, the IRF pursued two workstreams: (i) Mapping cost and activity data – collation and analysis of cost and activity data for health and social care; and (ii) Trialling new models of integration – development of new protocols for resource transfer and integrated service provision. The details of these are outlined below.

Mapping cost and activity data

2.4 The IRF mapping aimed to engage NHS and Local Authority partners in joint analysis of patient and locality level cost and activity information for health and social care. It was anticipated that this would provide a detailed understanding of existing resource profiles for partnership populations. In order to inform the broad objective of greater integration in the planning and deployment of health and social care resources, both within the NHS and between NHS and LA partners, two objectives for the mapping work were conceived at the outset of the IRF process:

- Measuring and understanding variations in the resources used for health and social care at the individual patient/client level;
- Measuring and understanding variations in health and social care resource use at higher levels of aggregation e.g. CHP/CHCP or general practice populations.

Trialling new models of integration

2.5 The second workstream aimed to develop relationships, both within NHS Scotland and between the NHS and Local Authority partners, in ways that would facilitate the realignment of resources to follow the patient/client as directed by care professionals and clinicians. It sought to develop protocols for more effective partnership relationships through improved governance, performance management and risk management.

2.6 This aimed to create worked examples of how integrated approaches could support shifts in the balance of care and improve outcomes for patients and communities by: increasing efficiency of allocation and utilisation of resources; improving equity of allocation of resources; reducing variation in inputs, outputs and outcomes; improving quality of care indicated by patient and user satisfaction measures and performance in relation to appropriate national outcome measures; and clarifying accountability for use of resources by clinical and care practitioners (see Appendix 1 for a list of pilot models).

Who was involved in the IRF?

IRF test sites

2.7 All NHS Boards and Local Authority partners have, since April 2008, been supported by the Scottish Government to undertake the first IRF workstream and map resources to communities. The Scottish Government also invited applications from NHS Boards and Local Authorities to take part in the second workstream of the IRF programme to trial new models of integrated working and develop worked examples of protocols for realigning resources. The selection process for this was completed in August 2009 and four test sites (comprising four Health Boards and 12 Councils) were identified:

- Highland test site: NHS Highland with Argyll & Bute Council and Highland Council;
- Tayside test site: NHS Tayside with Angus Council, Dundee City Council and Perth and Kinross Council;
- Ayrshire test site: NHS Ayrshire and Arran with East Ayrshire Council, North Ayrshire Council and South Ayrshire Council;
- Lothian test site: NHS Lothian with City of Edinburgh Council, East Lothian Council, Midlothian Council and West Lothian Council

2.8 Test sites were provided with financial support (£400,000 per site) between 2010 and 2012. This funding was designed to support organisational development, provide project management and free up local staff and professional time to implement mechanisms that would facilitate detailed mapping work and resource realignment. All test sites were expected to:

- Use the IRF approach to analyse and understand the cost, activity and variation of their current resource use patterns at population level (this was described as a mapping exercise).
- Undertake the mapping across Health and Social Care, linking-in other areas as appropriate.
- Use the Integrated Resource Framework to form the basis of a new approach towards planning and investment for resources.

2.9 However, within these boundaries, test sites were encouraged to take different approaches to developing IRF protocols and creating worked examples of resource integration. Three test sites (Ayrshire & Arran, Lothian and Tayside) opted to trial new ways of working with a number of smaller pilot populations based around localities, care groups or disease programmes.

Appendix 1 sets out descriptive details of each of the pilots identified across these test sites. Highland explored a similar approach to piloting new protocols for smaller populations but decided to undertake larger scale integration by introducing a Lead Agency model between NHS Highland and Highland Council in April 2012.

Policy context

2.10 The Integrated Resource Framework was developed in response to mounting evidence that current models of health and social care delivery are not producing the outcomes expected, with significant variation across the country. There are demographic pressures associated with an ageing population, as more people are living with the effects of serious chronic disease.[1] Although the health budget overall is forecast to grow over the next two years, this is at a slower pace than in previous years.[2] At the same time the NHS faces continued cost pressures, as demand for its services grow and increases in prices (e.g. prescription drugs) outstrip increases in funding.[3]

2.11 The IRF is driven by the priorities articulated in Better Health Better Care.[4] These point towards the majority of care being delivered in the community, as locally as possible, with a focus on improving health and reducing health inequalities; providing more integrated and targeted care in local settings; reducing hospital admissions; and providing systematic support for people with long-term conditions.

2.12 The Scottish Government developed its Shifting the Balance of Care (SBC) strategy in order to increase the emphasis on health improvement and anticipatory care, as well as provide more continuous care and ensure more support was available closer to home. The national SBC Delivery Group coordinated the work of NHS Scotland and the Convention of Scottish Local Authorities (COSLA) to develop the IRF. It aimed to support their shared strategic objective of shifting the balance of care by working across health and social care in a more integrated way. A review of Community Health Partnerships by Audit Scotland underlined the need for this.[5] It stated that integrating care involves significant and complex issues that no single partner can resolve on their own; and that there has been no significant shift in the balance of care despite this being highlighted as a key priority since 2000. Similarly, in their recent report on commissioning social care, Audit Scotland recognised the importance of joint planning and resourcing between NHS Boards and councils, in light of the interdependent relationship between health and social care services.[6]

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[1] The Scottish Government, 2010, *Improving the Health and Wellbeing of People with Long Term Conditions in Scotland: A National Action Plan*, Edinburgh: Scottish Government

[2] Scottish Government , 2011, *Scottish Spending Review 2011 and Draft Budget 2012-13* Edinburgh: Scottish Government, http://www.scotland.gov.uk/Publications/2011/10/04153155/10

[3] Audit Scotland, 2010, *Financial Overview of the NHS in Scotland 2009/10*, Edinburgh: Audit Scotland,

[4] Scottish Government, 2007, *Better Health, Better Care*, Edinburgh.

[5] Audit Scotland, 2011, *Review of Community Health Partnerships,* Edinburgh: Audit Scotland

[6] Audit Scotland, 2012, *Commissioning Social Care* Edinburgh: Audit Scotland

2.13 The IRF is, therefore, driven by the premise that more effective integration of health and social care, along with the voluntary and independent sectors, will improve the effectiveness and efficiency with which services are provided while at the same time working to improve outcomes and people's experience of services. It has the potential to enable partnerships to align their resources more effectively, providing better services without increased costs.

2.14 Since test sites began work to deliver IRF locally, there have been significant developments in the integration agenda. These have been informed by ongoing work in the IRF, and they are, in turn, giving added impetus to the process of change to which IRF has contributed.

2.15 In 2011 a Change Fund was introduced to support the implementation of the Reshaping Care for Older People Programme. Change Fund guidance was agreed by the Ministerial Strategic Group (MSG) for Health and Community Care and required local partnerships to prepare Change Plans that set down how the transitional funding would be used to achieve a shift in the balance of care. The MSG has overseen this development process nationally and local Change Fund plans were submitted to the MSG to ensure that a coherent national picture was achieved.

2.16 In December 2011, the Cabinet Secretary for Health, Well-Being and Cities Strategy announced that legislation will be introduced to Parliament with the purpose of revising Community Health Partnerships. Key elements of the new system will include the following:

- Community Health Partnerships will be replaced by Health and Social Care Partnerships, which will be the joint responsibility of the NHS and Local Authorities, and will work in partnership with the third and independent sectors
- Partnerships will be accountable to Ministers, leaders of Local Authorities, NHS Chairs and the public for delivering new nationally agreed outcomes. These will initially focus on improving older people's care and are set to include measures such as reducing delayed discharges, reducing unplanned admissions to hospital and increasing the proportion of older people who live in their own home, rather than a care home or hospital.

2.17 Consultation ahead of the introduction of new legislation has commenced following the local government elections in May 2012. Partnerships are currently working to develop their approach to joint strategic commissioning plans. Future development of Health and Social Care Partnerships will be an important element of this approach.

Evaluation aims

2.18 The overall aims of the evaluation were to: monitor progress in the test sites; assess the impact of the work of the test sites; feed evidence back into the process of change itself; and draw out implications from the findings for other partnerships moving towards financial and resource integration, both within and across, health and adult social care services in Scotland in the future.

Evaluation methods

2.19 The evaluation has taken place over three phases (a baseline review in summer 2010, an interim review in summer 2011, and a final review in spring 2012). Locally agreed evaluation frameworks were developed with each test site, to fit with national milestones and suggested measures of change, while taking into account the characteristics of each site.

2.20 Five main methodologies were used to gather information:

- review of IRF documentation in test sites
- reviewing processes and discussions at IRF Project Team and Programme Board meetings
- interviews with key strategic partners
- an email survey of delivery staff at each test site (carried out just after the baseline phase and repeated at the final phase of the evaluation)[7]
- focus groups with operational (patient and client facing) staff.

2.21 The information gathered during the baseline, interim and final evaluations was analysed using a diffusion of innovation framework adapted from Greenhalgh et al.'s work on the introduction of complex change in the English health service (see Appendix 2).[8]

Report structure

2.22 This report summarises progress across the test sites, identifying the positive impact of the IRF as well as the barriers and challenges faced. The focus is on the potential lessons that can be learned from this programme in the context of future integration of health and adult social care.

2.23 Chapter 1 gives an executive summary of the main findings and provides an overview of the lessons learned. Chapters 3 and 4 report on the creation and use of mapping information as a fundamental component of the IRF. Chapter 5 examines the ways in which test sites approached piloting service redesign and the possibility of resource realignment. Specific case studies are then considered in Chapter 6. Chapter 7 identifies the more general lessons that can be taken from this evaluation. Each chapter contains a key findings section which summarises the main points considered. The final section (Chapter 8) of the report outlines recommendations based on the report findings.

[7] All four test sites participated in the first round of the email survey but the Highland test site did not participate in the second round since the questions were not relevant to their local situation, where pilots were replaced by a commitment to a Lead Agency model.

[8] Greenhalgh T et al, 2004, Diffusion of innovation in service organisations: systematic literature review and recommendations for future research, *Millbank Quarterly,* 82(4): *581-629*

3 PRODUCING THE MAPPING INFORMATION

3.1 In all four test sites the starting point for IRF was to build an aggregate picture of health and social care activity, together with their associated costs, using NHS and Local Authority data. This mapping exercise began by looking at 2008/09 data. It was anticipated that mapping of cost and activity data across both partners would create a process which could be repeated more easily in subsequent years, thus adding the possibility of analysing trends over time.

3.2 In practice, at the outset of IRF, one test site (Lothian) elected to build a picture of resource use and costs at the level of individual patients and clients. The other three test sites took the decision to map costs and activity at the level of general practice, locality and CHP. Tayside test site decided in mid-2011 to apply a patient/client level approach to its data.

Progress with mapping NHS and Local Authority data

3.3 There has been progress in mapping health and social care data. All test sites undertook high level mapping of Local Authority and NHS cost and activity across health and adult social care. It was reported that this was the first time that mapping information across the partners had been undertaken and it was found to be helpful in building a more complete picture of activity patterns and the associated costs.

3.4 The first attempt at mapping 2008/09 cost and activity across health and social care was not straightforward and encountered a number of challenges. Some of these challenges were overcome, some were worked around and others continue to limit the accuracy, acceptance and use of the mapping data. These challenges and the steps taken to overcome them are discussed in paragraphs 3.5 to 3.25 below.

3.5 The process has been streamlined since the first iteration of the mapping and, for 2009/10, the Scottish Government and NHS National Services Scotland Information Services Division (ISD) have worked with partnerships to produce "all age", "over 65" and "over 75" health and adult social care mapped data for all partnerships in Scotland. This has reduced the workload burden for partnerships while ensuring greater consistency at the national level. The Scottish Government and ISD are currently working on the 2010/11 data for Scotland.[9]

Collating cost and activity data from different reporting systems

3.6 NHS and Local Authority systems for calculating costs and activity operate in different ways. Broadly speaking, Local Authority systems record direct costs charged for care, whereas NHS systems record activities and then allocate average costs to these. The mapping produced collated information from these different accounting systems based on a number of estimates and assumptions. This was reported to be useful in helping partners to make better sense of how resources are currently spent.

[9] Ayrshire and Arran have now mapped 2010/11 data.

3.7 The IRF mapping has helped to collate these two cost structures into single documents and has therefore simplified analysis of partners' spending and activity. However, there remain challenges in apportioning costs across different systems. One of the most obvious differences between the systems is the way in which they allocate overheads – NHS overheads are included in the average costs applied to each activity whereas Local Authority overheads are normally accounted for separately. Resolving these differences to include costs on a like for like basis is not easy. These differences can be acknowledged and accepted when the purpose is discussing variation in spend in different geographical communities (e.g. the total spend on the 75+ population in the different local authorities with the NHS board). However, when the analysis goes a stage further, and discussions focus on potential transfer of resources between partners, then the different accounting systems become more problematic (e.g. in transferring spend from one partner to another, different ways of allocating overheads can be much more contentious.)

Different levels of mapping

3.8 Stakeholders reported that the mapping information was built on assumptions and estimates which make practical sense at a macro level but become less robust as the data is broken down to more detailed levels. Test sites have each seen value in the mapping process but reported that the main benefits were achieved by mapping health and social care information down to CHP level. At this level, assumptions about the mixed approach, of breaking down overheads and building up patient level costs and activity, were generally accepted by partners as reasonable. Moving to more detailed information started to raise questions of credibility and confidence in how community health and social care costs are produced and applied.

3.9 Currently, the mapping data can be used to examine hospital-based care and community-based care at NHS Board level, CHP level, and for some activity at the level of GP practice. Hospital based activity is built up from individual patient records and can be analysed by geographic area, GP practice or age grouping. A large proportion of hospital costs can be mapped at an individual level using centrally collected SMR and prescribing data. This enables 67 percent of NHS Board expenditure to be mapped at individual level, a proportion that increases to 78 percent for people aged 65+ years, and 80 percent for those aged 75+ years. The community based activity delivered by the NHS can be analysed at CHP level but becomes less robust when broken down below CHP level.[10] Similarly, Local Authority spend is only available at an aggregate level by CHP.

3.10 When looking at the costs for a whole NHS Board area, all health costs and Local Authority spend should be included. This eases the pressure resulting from any differences in the way that costs are apportioned. Test sites reported that producing and analysing mapping data at this level was robust and useful.

[10] A notable exception is in NHS Tayside where a more extensive community health database is in place.

3.11 The process of producing cost and activity data across Local Authority areas within an NHS Board was susceptible to anomalies wherever health costs could be skewed by location of Board-wide facilities located within a council area. For example, Ayrshire and Arran found that the costs of Allied Health Professionals (AHPs) were allocated to hospitals rather than to the communities in which the AHPs were active. This weighted costs more heavily in council areas where the hospitals were located. In another example, Dundee stakeholders reported that many residents do not live in the same geographic locality as their general practice.[11] Test sites reported that undertaking the mapping process had proven helpful in creating a better understanding of how to produce aggregated NHS Board and Local Authority data to take account of the different geographical boundaries.

Data sharing and confidentiality

3.12 Respondents in the e-mail surveys noted frustration at the lack of data sharing between the key stakeholder organisations. Stakeholders cited lack of willingness to share data and lack of consistency in available data as the main challenges for data sharing. One example of work to address this is in NHS Tayside where the Chief Executive is now taking forward work to establish a generic data-sharing agreement.

3.13 Test sites reported that information on health community based activity and costs are underdeveloped across Scotland. GP community health activity data, such as district nurse contact hours, is not yet included in the IRF dataset.[12] Test sites reported that some GPs are reluctant to release this data in some cases because of concerns that resource use profiles will enable individual patients to be identified. They require detailed information about the use to which such data will be put and the steps which will be taken to anonymise the data, in order to agree to its release. The Scottish Government and ISD recognise that this is an important element in shifting the balance of care and are working to improve the information available. Options to do this are under review, including using sample data from a subset of general practices.

3.14 It was reported that data protection presented significant challenges, both in terms of Local Authorities passing data to the NHS Board, and the NHS Board returning mapped data to Local Authorities. For example, the need to define individual agreements between NHS Lothian and each of its four Council partners created considerable delays during the mapping process. It was reported that detailed national guidance in this area would be desirable to expedite data sharing agreements in the context of resource integration in future.

[11] ISD compared GP practice address and postcode of patient residence for Dundee city GPs and found that there were fewer patients living outside the catchment of their general practice than previously assumed. Patient-level data aims to overcome this problem where it continues to be an issue.

[12] The exception to this is Tayside which has an extensive community health database in place.

3.15 As described in 3.5 above, the Scottish Government is supporting NHS Boards and Local Authority partners as they work to map health and social care cost and activity at as granular a level as possible. ISD and Scottish Government Health Analytical Services Division (ASD) are supporting this work with the aim of adding impetus to the mapping process and making a stronger case for consistency within and between partners. All NHS Boards have agreed to participate in developing a standard patient level costing methodology, overseen by a costing advisory group convened for this purpose. NHS Boards and their Council partners are being encouraged to establish local costing groups to ensure consistency within partnerships.

Different approaches to mapping in the test sites

3.16 The mapping process was not routinely undertaken by partners so additional resources were required to manipulate data from different local systems. This meant that test sites had to make decisions about the point at which further mapping detail no longer justified the additional effort required. Three related factors affected this: (i) the resources available to produce the mapping data; (ii) the credibility of the mapping data (as described in 3.9); and (iii) the potential for the mapping data to affect resource realignment.

3.17 Analysing information in greater detail – to a patient level for all health and social care – was reported to be very time intensive. Therefore, Ayrshire & Arran, Highland and (in the first instance) Tayside undertook this level of "drill down" mapping only for specified groups of patients associated with the IRF pilots.[13]

3.18 In contrast, Lothian's decision to map at the patient level for all services took longer and required a significant commitment from staff involved. Local partners maintain that this approach holds considerable potential for a much more detailed understanding of cost and activity. Partners in Lothian are now working to show how this detail can be translated into better decision making, more efficient and effective service provision, and improved outcomes for patients. Another challenge that Lothian has worked to overcome is how to take the large volume of data created by this system and present it in a format that is simple enough to be useful. While this work remains ongoing, service planners responded positively when presented with the level of detail about costed care pathways which this work has produced.

Local flexibility and national coordination of mapping data

3.19 Test sites reported that flexibility to develop local systems for working out costs was useful in helping test site partners to assume ownership of the mapping process and of the data produced. As noted elsewhere in this report, local stakeholders consistently indicated that acceptance of the validity of the mapping data was very important. Flexibility to build cost data in a way that made sense at a Local Authority and NHS Board level was therefore reported as a positive element of the IRF approach.

[13] In Highland, this was superseded when partners decided to attempt a full Lead Agency model of integration rather than piloting smaller scale integrated financial mechanisms.

3.20 Flexibility to design local approaches to mapping enabled this to best fit the expectations and uses of each test site. However, it also makes it more difficult to build a consistent picture of health community care and Local Authority social care costs across the country. This may complicate analysis of activity and costs that cross council or NHS Board boundaries and would undermine attempts at national benchmarking. It also requires more resources for each area to build local systems for the mapping if they do not have a template to follow.

3.21 When the mapping was carried out as a one-off exercise for the first phase of the IRF, the local approach was reported to be appropriate and the mix of methods justified. However, the mapping is now being repeated on a more regular basis, thereby strengthening the argument for standardisation. By making use of the learning from the mapping approaches used in each test site, the Scottish Government is working with ISD to simplify and prioritise the information gathered. This holds the potential to increase the efficiency with which mapping data can be produced, and the ease with which it can be compared, within and across sites.

3.22 Whether the mapping is carried out using local systems or national templates, the information is currently limited to data already captured by existing data systems. It was reported that, if an integrated resource framework was being designed from scratch, then it would be reasonable to design integrated systems focused on gathering information relevant to resource planning in a similar format across all local partners. However, test sites considered the cost and complexity of developing a new system specifically for this purpose, and transferring from individual accounting systems into a new information framework, to be prohibitively expensive and the process unnecessarily disruptive.

Potential to make the mapping more comprehensive

3.23 Examining the resources committed by health and social care partners represents a significant shift towards more integrated service planning and delivery. However, the cost and activity data included in the IRF mapping did not include public health activity which was reported to have a substantial effect on demand into the system. The IRF mapping focuses on making best use of resources within the health and community care system, but remains susceptible to demand pressures (obesity, alcohol problems, drugs misuse etc.) which are not currently measured within the mapping information. Stakeholders reported that there is scope to extend the analysis to look at, for example, demographic pressures, and future cost implications based on assumptions about cost of illness. For example the Scottish Government Alcohol and Drug Partnership (ADP) team has commissioned a study of whether the IRF can be used to produce information on the activity and cost of services used by substance misusers in Dundee City ADP. NHS Board and Local Authority social work activity datasets will be used to map partnership expenditure to individual and aggregate population levels.

3.24 IRF test sites also identified some additional partners whose work has an impact on health and social care (e.g. education and police departments).

Test sites were aware of the potential value of including a broader range of partners whose work can significantly affect the level and location of demand into health and community care systems. The significant challenges posed by attempting to improve integration across primary care, secondary care and Local Authority community care meant that this was the focus of initial pilot work across the test sites. However, partners repeatedly acknowledged that future work on integration needed to more proactively involve a wider range of partners. The work in NW Perthshire to develop consumption budgets for localities seeks to address this challenge (see Chapter 6).

3.25 The IRF mapping focussed on making best use of existing information in order to limit the extra work required. However, this limited the mapping to the quality of existing data collection methods. This potentially skews analysis on to what has traditionally been measured and may miss significant factors which are less easily quantified. One of the main concerns reported by stakeholders throughout the evaluation was that the mapping information does not include quality and outcome measures alongside the cost and activity data. The IRF pilots recognised the need to build jointly agreed quality and outcome indicators into the aggregate descriptive activity and cost data, but had not achieved this by the time of the final evaluation.

"There is an obsession with beds as measure of capacity...but we don't understand capacity in the community well. The information systems are less well developed in the community, and talk about patient outcomes doesn't stand up to the same level of scrutiny."

Key findings

- There has been progress in mapping health and social care data. All test sites mapped cost and activity across health and social care. It was reported that this was the first time that mapping information across the partners had been undertaken and that this was helpful in building a more complete picture of activity patterns and the associated costs.
- Flexibility to design local approaches to mapping enabled this to best fit the expectations and uses of each test site. However, it also made broader comparison across NHS Boards and Local Authorities more difficult.
- A large proportion of hospital costs and prescribing costs can be mapped at an individual level using centrally collected SMR and prescribing data. However, detailed information on community health and social care costs is not yet standardised or centrally collected raising questions of credibility and confidence in how data are produced and applied.
- Mapping at a patient level has raised significant data protection challenges. In order to share address this Local Authorities, NHS Boards and GP practices require clarity on the use to which such data will be put, and the steps which will be taken to ensure anonymity and confidentiality.
- The IRF cost and activity data did not include public health activity which was reported to have a substantial effect on demand into the system.

4 USING THE MAPPING INFORMATION

4.1 The previous chapter described progress made by the IRF test sites in developing aggregated cost and activity data for health and social care. It also outlined the challenges which the mapping process has encountered and the steps being taken nationally and locally to overcome these. The IRF programme was designed to enable partners to use the mapping data to inform the planning and provision of health and social care services. This chapter reviews the range of uses, and the variety of users, of IRF mapping data.

Uses of the mapping data

Openness and transparency

4.2 The process of working together to collate, test and refine this data was reported to have given NHS and Local Authority partners a better understanding of their own information as well as that of their partners. It was also reported that the process of producing the mapping information enabled partners to recognise the value of greater openness and transparency in sharing data.

> *"The IRF has facilitated a greater focus on public sector spending on individuals. While the council had knowledge of commitments to each individual, having a wider focus including NHS investment has been helpful."*

Iterative improvement of information

4.3 The credibility of mapping data is improving. The first iteration of the mapping data (based on 2008/09 data) attempted something new and innovative and therefore encountered a number of challenges to its credibility and the extent to which it accurately described cost and activity. This was, in part, due to uncertainty in looking at new information for the first time and also linked to an awareness of the number of contextual factors that could influence the data. By exploring the limits of the data and refining the mapping process used, the subsequent iterations are reported to have provided a better discussion of health and social care cost and activity data.

4.4 The first attempts at mapping focused mainly on delivering an overview of spend and activity across NHS and Local Authority healthcare at a fairly strategic level. Once this had been produced it helped inform partners of the total resource spend for one historical period. It was not used to influence budget setting and did not enable any trend analysis. Test sites that repeated the mapping for 2010/11 reported that this was helpful in improving the quality of the analysis as well as providing a sense of change over time.

4.5 Partners reported that repeating the process on an annual basis would improve analysis of trends and allow a degree of monitoring of high level indicators. (For example the Lothian data was reported as showing a reduction in trauma and orthopaedic expenditure in the over 65s which is

attributable to a decline in volume and/or complexity of care, rather than a reduction in prices). However, it was also reported that the value of the mapping data would be much greater if in addition to historical analysis, it was used to positively influence future budget setting and service redesign.

Different levels

4.6 Mapping took place at a number of levels reflecting local priorities and systems in each partnership area. As stated above, it aimed to inform discussion on how resources have been spent and to aid thinking about how they might be spent in the future. Mapping of total resources spent by NHS and Local Authorities on care provision was carried out at the following levels:

- NHS Board area – giving a more accurate assessment of the total resource available and the current level of associated activity. This was reported by test sites as being broadly achievable and of value to high level strategic planning.
- CHP area (usually aligned with Local Authority boundaries) – informing discussion on variation in spend and activity amongst areas (including comparison with NHSScotland Resource Allocation Committee (NRAC) apportionment). This was reported by test sites to be broadly achievable and was useful for informing CHP planning.
- GP practices – opening up opportunities for discussing how GP decision-making varies across a locality. Test sites reported a variety of attempts to create and share this data but encountered two significant challenges at this level. Some data analysis - such as variation in activity and referral patterns - was reported as accurate but its credibility was challenged on its limited ability to reflect local context or patient outcomes. Other data analysis – such as NRAC apportionment – was challenged by partners in the test sites on the basis that comparison became less accurate at this level of population.
- Patient populations based on age or disease groupings – informing discussion on how resources could be spent more efficiently or more effectively for particular clinical/care pathways or patient groupings. The pilots looked at drilling down mapping to this level and reported that it took time to do this for populations of tens or hundreds of patients and service users. It was possible to use this data to inform discussions which included a wider range of qualitative information and local knowledge.
- At a patient level – providing the potential to build up cost and activity information on the basis of locality, age, care setting or disease groupings. This approach was challenging for partnerships to attempt on their own and was initially only fully pursued in a systematic way by NHS Lothian. The Scottish Government and ISD are now working with Tayside on patient-level mapping to build on the progress made by Lothian. The Scottish Government and ISD plan to extend this to other partnerships during the course of 2012.

Different purposes

> *"IRF data is useful...because it makes you start to ask relevant questions about what it means, and why it happens, and start to think through those questions. But this needs to be facilitated"*

4.7 The mapping information was used in a variety of ways. The three main opportunities identified for the mapping data during the IRF programme were: addressing unwanted variation; improving outcomes; and increasing efficiency.

- **Addressing unwanted variation**. The plethora of ways in which care can be provided, along with the personalised needs of each individual, mean that variation is necessary and beneficial in providing flexible services. However, the IRF acknowledged that certain elements of variation warrant attention and the mapping data was used to examine some of these. For example, mapped costs at a CHP level were compared against an NRAC apportionment to see whether different geographical communities were receiving an equitable share of health and social care resources. Similarly, comparisons of GP referral behaviour, emergency admissions or prescribing could be made using existing NHS data, allowing partners to consider the reasons for variation and possible ways to address these.
- **Improving outcomes**. The mapping data could be used to help define, measure, and monitor outcomes. Production and discussion of a more complete set of activity data for NHS and Local Authority services enabled analysis of which activity is linked to desirable outcomes (defined by service providers' and service users' perspectives). For example, if place of care is important to patients, the mapping data can be used to monitor this and make a case for redistributing resources to support service improvements. This use of the mapping data was found to be more relevant at the level of the IRF pilots where mapping at the level of a smaller population can be linked more closely with patient/service user outcomes.
- **Increasing efficiency**. The IRF test sites started to identify ways of delivering health and social care services more efficiently. Two broad approaches to improving efficiency through integrated working were identified as: (i) assume the level of work as fixed and attempt to redesign services to reduce the cost of delivering this work; or (ii) assume the cost base is fixed and attempt to redesign services to increase the amount of work that can be delivered.

4.8 Within each of the purposes set out above, stakeholders reported that there were three possible levels at which the IRF mapping data could be used: a can opener; a dial; or a feedback loop:

- **Can opener**. This was where data was used to enable partners to start a dialogue on the use of NHS and Local Authority resources. In this situation the level of detail was often less important since its primary role was to bring about general acknowledgement that a particular area of health and social care was important and could benefit from further discussion and analysis. The key function was reported to be the production and sharing of data in a way that started partners talking about a new area or an existing area in a new way.
- **Dial**. Where an issue, care pathway or population has already been identified as important by partners (can opener), the next stage may require more detailed and precise data to inform discussion on how to address or improve the provision of services in this area. The key function of this data was to identify the particular indicators which would allow analysis of the interplay between related elements of health and social care services and identification of potential alternatives.

- **Feedback loop.** This use of the data assumes that the issues have been raised (can opener), and the relevant indicators agreed (dial). The specific value of this use of mapping information was to track costs and activity over time in order to allow partners to monitor the effect of any changes to service provision and inform further revisions.

Examples of mapping use in the test sites

4.9 Mapping data was used as a "can opener" by strategic stakeholders to better understand how resources are currently used. Analysis by partners of the initial mapping data was used to define the activities and costs which were worth tracking over time. In this way, the baseline mapping data enabled partners to formulate the questions with which to interrogate further iterations of the mapping. For example Lothian partners' interrogation of three years' of mapping data (2008-11) shows a reduction in admissions of over-85s, and they are now assessing whether this corresponds to an increase in adult social care provision.

4.10 Research and information managers at the City of Edinburgh Council (CEC) interrogated the IRF data set for 2008/09 and used it as a "dial" to identify key indicators which they wish to track over time: acute hospital episodes for patients receiving intermediate care; patterns of emergency hospital admissions of older Edinburgh residents by age group; Accident and Emergency attendance by persons receiving domiciliary care; type of social care service used by persons also receiving NHS care; and use of health and social care services by sub-groups of the older population. Repeating this analysis for subsequent years (as data becomes available) was reported as an important step towards informing strategic planning and the redesign of care pathways. The analysis format developed by CEC is now being used by East and Mid Lothian partners as they learn to interrogate their IRF data sets.

4.11 Similarly, in Tayside, the mapping data for three consecutive years is being used as a "feedback loop" to look at longitudinal trends within CHPs and to compare activity and expenditure between CHPs. Equity of resource use across the three CHPs is being examined for the period 2008/09-2010/11 for selected indicators including: emergency adult admissions; occupied bed days due to long term conditions; and emergency admissions from care homes.

More detailed information on cost and activity

4.12 Detailed mapping data was developed for populations based on specific localities. For example, in NW Perthshire mapping data is being used to help define the scope of services which will be included in their consumption fund (see section 6), with the possibility that this scope will extend beyond health and social care. Highland initially started to pilot a similar approach to creating detailed mapping of cost and activity for district level populations which could then inform future joint service planning. Under the Lead Agency model which is now the focus of integration in Highland, there are plans to develop this approach across nine newly formed districts.

4.13 Mapping data was also developed in more detail for populations based on specific disease grouping and care pathways, such as COPD patients in Ayrshire and Arran. In a similar way, some pilots "drilled down" mapping information on particular age groups such as young people with complex needs in North Ayrshire. These were used to enable partners to discuss potential cost pressures, geographical variation, and possible service improvements.

4.14 Mapping data at the patient/client level is being used to identify typical pathways through health and social care services. For example in Lothian, bespoke software has been used to look at the care pathways of patients/clients whose final destination is a package of residential care.

4.15 Detailed mapping identified potential improvements to services. Pilot projects mapped groups of tens or hundreds of patients and were able to analyse care packages ranging from hundreds of pounds up to those costing over one hundred thousand pounds per year. Analysis of this mapping allowed partners to look at:

- Clustering of patients, in order to compare this with location of resources.
- Location of care activity.
- Variation in costs between independent service providers.
- Appropriateness of existing care services and exploration of viable alternatives.

Users of the mapping data

4.16 The quality and relevance of the information provided was noted as affecting the extent to which stakeholders engage with its findings rather than comment on any perceived shortcomings in its production. With such a large volume of information, generated by different systems and based on different assumptions, there is a potential for data to quickly become complex and confusing. The experience of the IRF test sites indicates that a level of sophistication is required in understanding the audience with whom mapping information is being shared and the purpose for which it is being discussed. The experience of the test sites indicates that repeated presentation of data, in a consistent format targeted at the particular stakeholder grouping, increased familiarity with the process and reduced anxiety about mapping content. Appendix 3 gives a checklist of important considerations for sharing mapping data which have emerged from the evaluation.

Sharing mapping data with service planners

4.17 The mapping produced information that had not previously been available or shared amongst partners involved in health and social care. As noted previously, the process for compiling this information was also new and experimental, leading to a level of uncertainty in the quality of the resulting information. Sites recognised the importance of engaging with a range of stakeholders in order to ensure that the data was accurate enough to allow comparisons to be meaningful.

4.18 The developmental nature of the mapping information left it open to challenge and misinterpretation. As a result, some partners were reticent to discuss this information with wider audiences before all stakeholders had a chance to agree its validity and account for any mitigating factors in large variation. Test sites reported the requirement to balance the need for public accountability and scrutiny of any new data against the need to allow the data to be iteratively developed, so that its validity was well enough accepted to ensure that discussion was not sidetracked by spurious outliers.

"There has been good work around looking at costs down to a GP practice level but we haven't capitalised on this since there is a reluctance to bring this information into the open. There may be good reasons that explain the variation but we need to put this on the table and talk about it."

4.19 Test sites shared data at IRF meetings and were proactive in sharing this through CHP structures. These forums were seen as safe settings in which to analyse and constructively challenge drafts of the data in order to make it more reliable under wider scrutiny.

4.20 The IRF has been most successful in improving dialogue in structures and settings where partnership working was already on the agenda. Test sites reported greater difficulties in engaging with stakeholders who are not already involved in existing partnership structures. Staff involved in CHPs, locality planning groups, or IRF steering groups have a responsibility to plan, organise and manage services in an efficient, effective, and equitable way. As a result, information to support partnership working and integrated service planning was of obvious and immediate value to this group of stakeholders.

Sharing mapping data with service providers

4.21 The IRF recognised the limitations of providing health and social care with finite resources and increased demand. One of the key challenges that the IRF sought to address was how to empower and enable service providers to balance their remit to provide the best possible care for individual patients and service users against their responsibility to consider the care needs of the wider population. However, engaging with staff whose main role was direct delivery of care (GPs, hospital clinicians, social care managers etc.) proved difficult. The immediate demands of caring for the current needs of patients and service users make it more difficult to find time to step back and look at the impact on planning future services.

4.22 From the outset the IRF programme acknowledged that GPs were key stakeholders whose understanding and analysis of the mapping information would be essential to its ongoing usefulness. To this end, the sites used a variety of forums to engage with GPs on the mapping data including taking it to local groups of GPs, organising larger events to which GPs were invited and gaining input from GPs through existing partnership groups. However, sites reported little return for their efforts to engage GPs. The reasons given for this included:

- Professional groups are - to a greater or lesser extent - represented on committee structures. However, neither the extent of current representation, nor the flow of information between representatives and their professions, are clear at present.

- Events were organised which provided focused and protected time to engage with GPs or clinicians. These events were reported to have raised awareness but did not provide an ongoing engagement with the mapping information and were thus of limited value.

- There are significant costs involved in taking frontline staff away from patient contact. Test sites reported difficulties in getting locum time to allow engagement from local GPs.

4.23 The main difficulty encountered in persuading frontline staff to step out of a care-providing role to spend time thinking about service planning and resource realignment, was summarised in what was described as the "so what?" question. In essence, this recognises that staff have competing demands on their time and therefore need positive answers to two key questions before they will feel able to commit to any new process of change: (i) "does this affect me?"; and (ii) "can I affect this?". The experience reported by the test sites was that local partners did not make a clear enough case that the work of these individuals would be affected, nor how these individuals could affect the outcomes. Therefore the "so what?" question remained largely unanswered.

'This (mapping data) is probably not a lot of value at my level (frontline delivery). It's interesting and good to look at, but at a higher level, they should be looking at it hard"

4.24 The IRF has been supported by - and has itself supported - other policy agendas. However, to implement each policy or strategy requires staff time. Although it was generally reported that the policy direction of travel is consistent, the actual demands on frontline staff to discuss, plan and implement each policy initiative can be seen as competing.

4.25 Analysing financial and activity data is not a core skill for many of the frontline professions involved in delivering health and social care. Some stakeholders reported that training would be required in order to allow GPs, hospital clinicians and social care managers to make full use of the mapping information. This would facilitate a much more useful and progressive analysis of: (i) which issues may require data refinement; (ii) which require additional data; and (iii) which should result in actions to improve services.

4.26 As discussed above, it was difficult for GPs, hospital clinicians and social care managers to make time to look at mapping data since it is outwith the normal scope of their work remit. Training would itself require a time commitment from these professionals but may be needed for meaningful engagement with integrated cost and activity mapping.

Sharing mapping data with service users

4.27 Throughout all three rounds of the IRF evaluation, stakeholders reported the importance of public perceptions about the location, timing and quality of care. While some of the mapping data is recorded in public record, and therefore in the public domain, the IRF test sites did not focus significant effort on sharing the mapping data with service users or more generally with the public. This underlines the need to draw attention to the data which is in the public domain and develop strong skills in interpreting and presenting it.

4.28 Policy initiatives such as Self Directed Support and Anticipatory Care Planning were seen as key drivers in improving the extent to which patients/service users and their families are included in service planning. There was widespread recognition of the potential value of involving service users in the planning of their own care, while at the same time acknowledging that this could create an increased level of complexity in the management of integrated services. Test sites reported that the more detailed mapping information (at patient level or disease grouping) could be used to inform individual care planning discussions.[14]

Key findings

- The IRF mapping information was used to facilitate more open and transparent discussion of integrated working across health and social care. Test sites attempted to use the mapping to look at unwanted variation, identify potential service improvements and examine how services could be provided more efficiently.
- Staff involved in CHPs, locality planning groups, or IRF steering groups have a responsibility to plan, organise and manage services in an efficient, effective, and equitable way. Consequently, information to support partnership working and integrated service planning was of obvious and immediate value to this group of stakeholders.
- The potential of the mapping data to help define, measure and monitor outcomes was recognised but remains underdeveloped.
- Engaging with wider staff groups whose main role was direct delivery of care (GPs, hospital clinicians, social care managers etc.) proved difficult. The immediate demands of caring for the current needs of patients and service users make it more difficult to find time to step back and look at the impact on planning future services.
- The IRF programme was designed with engagement of GPs and clinicians at its core. However, the experiences reported by the test sites indicated that local partners did not make a clear enough case for affecting the work of these individuals nor how these individuals can affect the outcomes.
- While some of the mapping data is recorded in public record, and therefore in the public domain, there is greater potential to interrogate and then share the mapping data with service users, or more generally with the public.

[14] Issues of anonymity and confidentiality were reported to be very important if this use of the mapping is to be explored.

5 TRIALLING NEW MODELS OF INTEGRATION

5.1 The IRF process was clearly defined by the two complementary elements of: (i) jointly mapping resources and activity across health and social care; and (ii) developing new protocols to allow resources to flow between NHS and Local Authority partners. Ayrshire & Arran, Lothian and Tayside all chose to develop new ways of working with a number of smaller pilot populations based around localities, care groups or disease programmes. These pilots ranged in size, focus and purpose. In contrast, at the end of 2010, Highland test site took a decision to bypass the process of trialling small scale pilots of change as a means to testing out the potential of integration. Instead NHS Highland and Highland Council made a commitment at the most senior level in both organisations to undertake integration and realignment on a much larger scale using a lead agency model (see chapter 6).

5.2 At an early stage in the IRF programme, the Scottish Government set milestones in the expectation that test site trials for resource realignment would have new financial mechanisms in place by April 2011. However, none of the test sites were actively running new integrated financial and governance arrangements by the time of the final evaluation in March 2012.[15] Therefore, this evaluation is limited to analysis of the processes of setting up new protocols and does not comment on the impact of trialling resource realignment. This chapter reports on the degree of progress made in introducing new financial mechanisms and analyses the key challenges encountered.

Progress

Adding fresh impetus to existing partnership working

5.3 The IRF methodology was new and innovative but was introduced in the context of ongoing work to integrate services. This meant that test sites designed and implemented the IRF pilots in a range of ways reflecting local priorities and needs. This approach was reported as a positive opportunity for local partners to initiate new areas of joint working as well as developing existing areas. It built upon partnership relationships that were already in place as well as introducing new partners. However, this made it more difficult to draw a clear distinction between IRF pilots and other local partnership and national initiatives and policies. The following list exhibits the types of pilots that emerged:

- Pilots that were initiated by the IRF process and were resourced with additional IRF funding
- Local pilots that had been started prior to the IRF but were boosted with IRF funding and support
- Pilots that used IRF funding alongside other initiative funding for different policy priorities

[15] Highland started to implement the new Lead Agency model of integrated services in April 2012.

- Pilots that were included within IRF learning and reporting structures but did not receive any IRF funding

5.4 During the course of the evaluation, the test sites repeatedly gave examples of other partnership working initiatives which were not labelled as IRF but which nonetheless developed or demonstrated learning from an IRF approach. The growing number of partnership initiatives incrementally reinforces a culture of integration where traditional boundaries can be challenged and changed.

"You could get rid of the 'You work for social work, I work for someone else' and instead say 'we are the dementia team, we work for these people and we work these hours and conditions'"

Using local knowledge of need and opportunity

5.5 The selection of IRF pilots reflected local partners' knowledge of areas where partnership working was already recognised as having potential. This was usually based on jointly recognised priorities and an accepted sense of opportunity for service review and improvement.

5.6 For example, NHS Lothian and City of Edinburgh Council (CEC) partners decided that the implementation of a new model of care within orthopaedic and stroke rehabilitation pathways had considerable potential to shift the balance of care from hospital to community settings. This decision followed on from the NHS Lothian Strategic Model of Care and Capacity Review for Older People in 2006, and was informed by benchmark information. A phased implementation of this approach was planned during 2010/11. This coincided with Lothian's bid to become one of the IRF test sites, making it logical to use this project as the IRF pilot for the CEC partnership area. The aim of the model was to shift the balance of care from hospital to community settings, with a related objective to enhance rehabilitation in hospital in order to increase the functional level of patients at their point of discharge.

5.7 Similarly, the decision to select NW Perthshire as one of the Tayside IRF test site pilots was influenced by a range of local factors. These included successful community engagement around reconfiguration of community hospital beds, the particular needs of a rural community, and an interest in extending successful models of joint working to deliver more integrated health and adult social care services to a wider integration agenda.

Focusing effort and adding detail

5.8 The pilots were used by some test sites to take a more detailed look at the types of information that could inform integration. They identified populations based on geographic boundaries, age groupings, care pathways and disease groupings. The more detailed work on costs and activity for these populations addressed some of the limitations of the much broader mapping exercise commented on in chapters 3 and 4. The pilots focussed on: patient level costs for an identified patient population; staff views on service provision for

identified patient populations; and potential changes to service provision and anticipated outcome measures.

5.9 Some pilots initially defined a scope that was too large to undertake within the prescribed resources and timescales. For example, initially the work in Ayrshire and Arran attempted to look at young people with complex needs across North, South and East Ayrshire. However, in order to make progress the scope was revised to a more targeted piece of work within North Ayrshire.

5.10 The pilots that appeared to make quicker and more obvious progress took a more pragmatic approach and restricted the scope of their ambition to a manageable geography, population, number of service partners and impact. For example, the Lothian work on phased implementation of orthopaedic and stroke rehabilitation pathways involved a very specific patient population, namely orthopaedic patients in two wards at the Royal Victoria Hospital and stroke patients in one ward at the Astley Ainslie Hospital.

Encouraging leadership

5.11 The test sites put in place structures to organise the IRF process. Senior strategic partners were represented on steering groups and implementation groups with the intention that these would coordinate and drive the mapping and pilots. More than three quarters (77 percent) of service delivery staff who responded to an email survey reported that there was senior buy-in to the IRF from their organisation. However, this did not necessarily equate to leadership since only 56 percent of the same group of respondents reported that the IRF had visible leadership.[16]

5.12 The evaluation found evidence that leadership was more effective where senior managers were actively involved within both partner organisations. It was also reported that leadership could be provided by staff at different levels within each organisation who took a proactive approach to encouraging colleagues to consider new integrated ways of working. Positive leadership and trusting relationships were reported to be crucial to building momentum for change.

"'Barriers are really down to personalities – mutual understanding and relationship, irrespective of structure, is what makes a difference."

5.13 The experience reported in Highland (see chapter 6) indicates that political and executive level leadership is key to enabling full scale trialling and implementation of new financial mechanisms and governance arrangements. This was reported as necessary to overcome the inertia within different systems which implicitly acts to dampen the scale and rate of change.

[16] Based on 44 responses from stakeholders in Ayrshire & Arran, Lothian and Tayside during the second iteration of an email survey in February 2012.

Giving staff time to reflect on practice

5.14 Integrated working was reported to be happening in a 'bottom-up' manner. Front line staff in health and social care reported examples of how they work together - and want to work together more - for the benefit of service users. This was often reported to occur despite organisational structures and systems rather than because of them. The pilots re-enforced examples from other partnership initiatives in showing potential localised benefits of local staff being given time to reflect on practice and develop and lead service improvements. For example, in one of the Perth and Kinross workstreams, front line staff reviewed the discharge planning process, developed and integrated an efficiency improvement that was reported to have freed up a significant amount of social work time. Similarly, in East Ayrshire, the IRF enabled existing staff to take time to research current services for adults with complex needs and create recommendations for future improvements.

Introducing the philosophy and language of commissioning

5.15 The test sites reported that the IRF programme had been helpful in providing examples of models for trialling new financial mechanisms; in sharing experiences from elsewhere in the UK; and in publishing a literature review of evidence in this area. [17] The test sites reported improved understanding amongst stakeholders of the terminology of commissioning and the possible financial mechanisms involved. For example, Ayrshire and Arran undertook a specific workstream to develop locally agreed governance and financial mechanisms to support local integrated working. This resulted in a document outlining the possible integrated governance arrangements.

5.16 Partners reported an increased awareness of the value of introducing some form of commissioning to link the cause and effect of spending decisions. It was reported that the IRF had helped to articulate the instability within the health and social care system where currently those making decisions on the place and type of care are not directly affected by the costs of their decisions. It was acknowledged that integration needs to legitimise the tension across the system so that those who make decisions have some form of direct feedback about the resulting cost implications.

> *"If a CHP wants to influence a hospital then it doesn't need to know how much each procedure costs or detail on a patient by patient level. What it needs to know is that if GP practices make changes that result in reduced admissions and reduced length of stay then that frees up a certain amount of cost that can be looked at by partners."*

5.17 The evaluation found evidence across the test sites that joint strategic commissioning needs to be more explicitly implemented in the health and social care system to address the issues raised by improved information. The mapping data and the trialling of new ways of working raised the profile of variation, opportunity cost and potential improvements in efficiency. However,

[17] Weatherly, H. et al 2009 *Financial integration in health and social care: Evidence review.* Scottish Government: Edinburgh.

it was reported that integration needs both information and incentive to effect change. The IRF brought into sharper focus the difficulty of addressing these issues when there is no direct financial mechanism to link decisions concerning demand and supply across the whole of the health and social care system.

Challenges

Uncertainty and speculation

5.18 The IRF, the Change Fund and the Cabinet Secretary's announcement concerning the reform of CHPs, all share a common objective to deliver more integrated health and social care.[18,19] The consistent policy direction was reported to be helping to create a culture of integration. However, the policy direction outlining the extent of service changes emerged over time, and this was linked to a degree of uncertainty amongst local partners. During 2011, stakeholders reported increasing uncertainty caused by speculation about national proposals for changes to Community Health Partnerships which could involve greater integration of budgets and accountability. This led to uncertainty about the IRF and some stakeholders reported a degree of reticence about expending effort to trial new financial mechanisms until the national direction was clarified. The notable exception was the Highland test site where, in April 2012, NHS Highland and Highland Council introduced a Lead Agency model for Health and Social Care with delegated budgets for adult social care.

Scale of integration

5.19 The IRF pilots aimed to enable test sites to try out integrated financial mechanisms on a limited scale, with the expectation that these would produce a stronger evidence base which would encourage wider implementation. However, progress in the pilots was limited by the fact that some were small scale trials and therefore did not receive the long term commitment needed for partners to deliver much more than marginal change. However, as the evaluation developed, there were signs of progress, such as the consumption budget work in Tayside and the Lead Agency model in Highland, which continue to build momentum at a more significant level.

Transferring resources

5.20 As noted above, by the time of the final evaluation, the IRF test sites had not yet implemented new governance arrangements or financial mechanisms and there was a lack of evidence that the IRF had influenced a change in the use of resources. A quarter of service delivery stakeholders surveyed indicated that the IRF had helped clarify decision making but only five percent reported that it had enabled the flow of resources between health and social care.[20]

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[18] http://www.scotland.gov.uk/Topics/Health/care/reshaping/changefund

[19] http://www.scotland.gov.uk/News/Releases/2011/12/12111418

[20] Based on 44 responses from stakeholders in Ayrshire & Arran, Lothian and Tayside during the second iteration of an email survey in February 2012.

5.21 Partners involved in the research cited examples from the IRF and other partnership initiatives which have made better use of resources in one part of the health and social care system to change the place or type of care for particular groups of patients. However, the evaluation did not find evidence of this sort of change leading to savings being released or resources being transferred across different parts of the systems. Analysis by the test sites indicates that the underlying issue is poor cross system demand management which back-fills any space created by new ways of working.

Addressing fixed costs

5.22 Fixed costs remain a big challenge for health and social care. The IRF has helped to support the case for shifting the balance of care by continually placing the idea of opportunity cost into discussions on the best use of resources. However, better mapping data and improved dialogue amongst partners have not yet evidenced an influence on decision making to disinvest resources which are tied up in staffing or buildings.

> *"The big barrier that is starting to be acknowledged by stakeholders is that the reality of shifting resources is being hampered by different definitions of fixed costs. If beds, consultants, wards and ward staff are all regarded as fixed costs, then the options for shifting the budgets associated with the improvements aspired to in shifting the balance of care are unlikely to be achieved."*

5.23 The mapping data and the work undertaken by IRF pilots have started to identify areas where integrated working could create both improved ways of working and changes in the demand structure across the health and social care system. However, stakeholders reported that fixed costs form a barrier in shifting towards more integrated ways of working. Three main areas were identified: (i) a negative public perception of changes which lead to a reduction in physical resources such as hospital wards or day care centres; (ii) political commitments to protecting changes in staffing levels; (iii) an historical mindset which persists in inappropriately defining the majority of costs as fixed.

5.24 It was reported that the case for addressing fixed costs could be enhanced by:

- A better understanding of how cost and activity data for health and social care is linked with patient outcomes
- A better evidence base for the risks associated with changes in recognised care patterns which is also better shared and understood by all those involved (politicians, planners, professionals, patients and the public)
- Partnership structures which have better representation of all relevant stakeholders and also the power to change the use of resources across care settings and care pathways
- Referring to examples of success in reducing fixed costs where this is planned and managed over a defined period, for example the deinstitutionalisation of mental health care in the 1990s.

5.25 Decisions to disinvest in current staff and buildings are highly contentious and require: a stronger evidence base of the benefits of disinvestment; committed leadership from politicians and service Chief Executives that fixed costs can be redefined; greater public confidence in decision making bodies where fixed costs are to be redefined; and clearer communication of the motives and benefits of changing the composition of buildings and staff used to deliver services.

Balancing representation

5.26 Stakeholders involved in the process reported that it was much simpler to get representation on partnership projects from people who were involved in management than it was to get meaningful representation or engagement with groups such as GPs or hospital clinicians. One of the key challenges was the significant variation in geographic responsibilities of different professional or staff groups. Some examples of the complexities of this are given below:

- An NHS manager is likely to be responsible for a particular service across the whole NHS Board and can therefore find it difficult to develop partnership working with one Local Authority in a way that creates a 'postcode difference' in quality of care within the NHS board area. This was described as inhibiting more innovative work based on a Local Authority level, because it might be seen as creating postcode-differentiated care provision.
- A Local Authority service manager is responsible for services within one Local Authority area but has much more limited scope, to influence policy or practice, in neighbouring Local Authorities within the same NHS Board area. This was reported as making it more difficult for Local Authorities to engage with integrated work at an NHS Board level, without individual representation from each Local Authority involved.
- A GP works in independent practice with responsibility for a smaller population of patients. The independent nature of GP practices was reported to make it difficult for GPs to act in a representative way beyond the scope of their own practice. Engaging GPs in a NHS board-wide consideration of integrated working was, therefore, seen as requiring engagement with large numbers of GPs. This implied significant costs for locum cover in order to facilitate widespread attendance (especially if this was to be an ongoing dialogue rather than a one-off event).

Creating incentives to participate

5.27 The mapping information produced by the IRF and the new models of working piloted in the test sites are strengthening the evidence for changing the way in which services are planned and delivered. However, the IRF information and emerging examples were reported to be limited to effecting marginal change unless relevant stakeholders were given clear incentives to integrate and the power to influence more substantial change. Only 11 percent of service delivery stakeholders surveyed during the final round of the evaluation reported that the IRF had empowered frontline staff to improve services.[21]

[21] Based on 44 responses from stakeholders in Ayrshire & Arran, Lothian and Tayside during the second iteration of an email survey in February 2012.

5.28 The experience of the test sites highlighted four key factors which could incentivise professional staff to get involved: patient outcomes; professional standing; financial reward; and workload balance. Where these were present and recognised, engagement in service change was more likely. These are discussed in more detail below.

5.29 Patient outcomes – "Does this integration agenda improve the care of my patients/clients?" Stakeholders involved in the direct delivery of care reported that they prioritised changes where there was a direct link to the quality of care provided to the population for whom they had a caring responsibility. The evidence from the email survey of service delivery stakeholders was that over the period in which the IRF ran, their confidence that the IRF would directly affect patient/user outcomes dropped significantly from 6 to 3.[22]

5.30 Professional standing – "Does this integration agenda make me better at my job or make my job more valued?" Many of those involved in service delivery (e.g. GPs and hospital clinicians) have chosen this as a vocation and have committed many years to training and skills development in order to practice their chosen profession. Where an integration agenda and process maintains clear professional boundaries, explicitly values the roles of different professions and provides security about future employment then service delivery staff may be incentivised to get involved. However, in the short term, the service change involved in integrating different services was reported as creating levels of uncertainty about new professional roles and responsibilities. For example, where integrated working seeks to shift the balance of care and potentially reduce the amount of care in acute settings this could be a disincentive for acute sector workers who may have concerns about fewer jobs and reduced responsibility.

5.31 Financial reward – "Does this integration agenda improve my financial standing (increased remuneration, where income is directly affected by activity or improved efficiency, where staff performance measures are partly based on ability to deliver within budget or achieve savings targets)?" In recent years, there has been a move towards using financial rewards to lever changes in the ways services are provided. For example, the General Medical Service (GMS) contract linked the Quality and Outcomes Framework (QOF) with the financial rewards available to General Practices. In recent years, efforts to improve the management of different parts of the Health and Social care systems have increased. For example, the GP contract created a greater degree of control over the working priorities of general practices by awarding QOF points (linked to financial payments) to a variety of behaviours seen as beneficial to patient outcomes. However, the experience of the test sites showed that initiatives such as the IRF, which are not directly included in such incentivised schemes, are unlikely to receive as much attention. It was reported that a national review of the GP contract may be the best way to do this. The IRF did not create any explicit links between engaging in the process of change and any sort of financial return. Stakeholders reported a lack of financial incentive to engage with the process of integration. Hence it was a

[22] Confidence level was rated on a 10 point scale where larger numbers represented greater confidence.

lower priority than other activities which had an immediate and positive financial reward.

5.32 Workload balance – "Does this integration agenda make my work balance easier (reduce demands on my time or allow me to make better use of my time)?" One of the driving forces for integration is that services are currently under significant pressure to deliver the amount of care required by an aging population. Frontline staff are, therefore, already very busy and are looking for ways in which workloads can be decreased or better balanced. In this context it was difficult to find staff able to take time out of delivering care in order to look at longer term efficiencies and quality improvements.

5.33 One of the key issues highlighted by this analysis of the IRF test sites was the challenge posed by the short term barriers to effective participation. The experience of the test sites indicated that the early stages of trialling new integrated models of working may experience difficulties such as: lack of evidence to link proposed service changes and improvements to patient outcomes; increased professional uncertainty during a time of change; additional start-up costs to implement new ways of working while ensuring smooth service transition; and additional time commitment expectations placed on already busy professionals.

5.34 Results from the two rounds of the email survey indicated that, between 2010 and 2012, service delivery staff remained confident that their organisations were committed to the IRF. [23] However, these staff also reported decreasing levels of confidence that the IRF would improve joint working between health and social care. [24] Stakeholders reported that these short term disincentives should either be addressed directly or a much stronger link made with the anticipated benefits that could result in each of these areas in the medium or long term.

Key findings

- Test sites made quicker progress when they took a pragmatic approach to integration by building on existing local knowledge and relationships. These sites restricted their scope to a manageable geography, population, number of service partners and ambition of impact. An alternative approach taken in Highland indicated that more ambitious change could be introduced where local leadership was willing to extend the timeframe for implementing change.
- The IRF test sites found that it difficult to get meaningful representation or engagement with groups such as GPs or hospital clinicians. There are four key factors which could be used to incentivise greater engagement with delivery staff: patient outcomes; professional standing; financial reward; and workload balance. Where these were present and recognised then engagement in service change was more likely.

[23] Mean responses for both rounds of the email survey remained around seven. Confidence was rated on a ten point scale where larger numbers represented greater confidence.
[24] Mean scores in the three test sites participating in both rounds of the email survey decreased from 5.5 to 2.8, from 4.8 to 4.5, and from 5.8 to 3.9. Confidence was rated on a ten point scale where larger numbers represented greater confidence.

- The test sites did not implement financial mechanisms within the expected IRF timeframe due to a range of factors including announcements by the Scottish Government on next steps for policy on integration.
- The IRF raised partners' awareness variation in activity and in costs. However, it also brought into sharper focus the difficulties of improving efficiency and addressing unwanted variation when there is no direct financial mechanism to link demand and supply across the health and social care system.
- The IRF helped to support the case for shifting the balance of care by continually placing the idea of opportunity cost into discussions on the best use of resources. However, there was a lack of evidence that the IRF has influenced transfer of resources, and fixed costs remain a significant challenge.

6 CASE STUDY LEARNING

6.1 This chapter describes some of the learning from worked examples in each of the test sites. The first three examples (one each from the Ayrshire and Arran, Lothian and Tayside test sites) trialled integrated working with pilot populations based around localities, care groups or disease programmes. These were nominated by test sites as exemplars of work where demonstrable progress has been achieved, and where lessons have been learned which may be applicable in other areas. The final example gives some of the emerging learning from Highland which has introduced a lead agency model between NHS Highland and Highland Council.

East Ayrshire – adults with complex needs

6.2 The East Ayrshire IRF pilot focused on researching the individual elements of care provided to adults with complex needs. The pilot looked to describe and improve understanding of the profile of clients within the target group, the range and cost of services provided for the target group, and the provision of joint commissioning of services for the target group.

6.3 Key elements of this methodology included:

- Identification, by NHS and Local Authority learning disability and mental health teams, of caseload clients considered to be 'complex'
- Data collection in relation to those clients regarding service involvement and needs
- Interviews and focus groups with staff and management designed to survey their experiences of integration
- Exploring the application of Self Directed Support approaches across Scotland.

A pragmatic approach

6.4 The East Ayrshire pilot was widely acknowledged to have been a useful project that initially resulted in improved information for a particular patient grouping and subsequently produced a joint action plan to respond to this analysis. The project team reported that progress was linked to an existing knowledge of the services and of realistic appraisal of the extent of partnership working, together with a sense of optimism about what it would be possible to achieve. The project carefully considered the funding level, the timescale and other local drivers and barriers before defining a realistic opportunity for better integrated working.

Balancing partners' aspirations with their sphere of influence

6.5 The pilot remained focused on areas that were within what partners saw as a realistic sphere of influence. The range of options explored reflected the sense that integration could be implemented at a variety of levels and did not necessarily require new or changed resources to affect change. For example, recommendations from the initial pilot work ranged from a simple change in terminology (changing "risk assessment" to "safety assessment") through to

consideration of joint funding of support workers in Community Mental Health Teams.

Positive partnership relationships

6.6 The analysis was carried out by staff seconded from NHS Ayrshire and Arran and from East Ayrshire Council. This was seen as underlining the partnership approach to the work and encouraged "buy-in" from staff in both organisations. These individuals already had a network of relevant professional relationships and were reported to have the respect of their peers. This gave the pilot credibility and a "running start" in accessing relevant partners and in sharing information.

Balancing qualitative and quantitative information

6.7 This pragmatic approach continued throughout the pilot as evidenced by its recognition of the limitations in mapping quantitative service costs to a patient level, balanced by qualitative information on what service providers thought could improve delivery.

Prioritisation of actions

6.8 The East Ayrshire pilot undertook some detailed research which produced a detailed report with 21 high impact recommendations. Partners prioritised these into a detailed action plan for implementation.

Importance of understanding shared aims and outcomes

6.9 Shared ownership of the project was reflected in partners' commitment to undertake the research and follow this up with an action plan to take forward recommendations. Partners acknowledged limitations in transferring budgets to support this work stream. A more detailed understanding of shared strategic aims matched with a suitable set of metrics to monitor shared outcomes were reported as potential next steps to improving integration on a larger scale.

Edinburgh – orthopaedic and stroke rehabilitation

6.10 The objective of the NHS Lothian and CEC orthopaedic and stroke rehabilitation workstream was to shift the balance of care from hospital to community settings. A related objective was enhancing rehabilitation in hospital to increase the functional level of patients at their point of discharge. Ongoing rehabilitation and care needs would be delivered to patients within their own homes, through enhanced rehabilitation and social care support. This would in turn support a higher volume of earlier discharges from hospital for patients. Performance measures such as length of stay (LOS) were used to assess impact. Additional resources were targeted across hospital and community settings.

6.11 A full financial evaluation will be conducted when IRF data is fully updated with information from the period of time during which the exercise was conducted. The longitudinal data for 2008/9 to 2010/11, which the full IRF

dataset will contain, will be revealing here in providing information about resource impact along the whole care pathway. While reduced LOS will reduce marginal acute inpatient costs (and eventually potentially some fixed costs if the new model of care is rolled out on a big enough scale) it will be instructive to find out the cost impact on other parts of the system e.g. re-ablement and other aspects of home care packages.

6.12 The model is now being rolled out across all 12 clinical sites in Edinburgh treating orthopaedic and stroke rehabilitation patients, with funds allocated from Change Fund resources for Community Therapy services; re-ablement; day services; community nursing; enhanced supported discharge; and equipment and adaptations

Significant reductions in length of stay for patients

6.13 Average LOS for orthopaedic inpatients reduced by just less than 14 days, and for stroke inpatients by just less than 13 days (although it should be noted that numbers of stroke patients were small). A net increase of 36 percent was recorded for the re-ablement caseload, attributable to patients being discharged via the orthopaedic rehabilitation pathway at the RVH. A net total increase of 10 per cent was recorded by the entire re-ablement service, compared with the previous year's performance. In terms of patient outcomes, patients were able to access downstream hospital and community services more quickly than previously, fewer waits for onward care were experienced, and a higher throughput of patients from rehabilitative hospital settings into the community was achieved against the baseline.

6.14 It is estimated that the phased implementation project tackled up to 90% of the "delayed discharge" element of existing pathways, and that the pilot removed logistical barriers in care pathways. It was also reported that the remaining 10% will be much harder, if not impossible, to tackle, in part because of received wisdom and entrenched ideas about the treatment of frail elderly patients. Some Charge Nurses have been very proactive in organising discharge decisions. The bulk of LOS reduction has come from removing logistical barriers in care pathways, followed by organising more timely rehabilitation on the ward. One observer predicted that LOS will eventually plateau, as more elderly patients are admitted with more complex needs.

Differing perceptions of risk

6.15 Some clinical specialists (AHPs as well as clinicians) are wary of discharging patients into what they consider to be less specialised community services. This is affected by perceived levels of risk. A series of sub-decisions are involved in deciding to discharge a patient and only when these are all perfectly aligned does the patient actually leave the acute setting. Not all clinicians and AHPs recognise that it may not be possible to control all elements of a discharge plan, and that every discharge entails some management of risk.

The importance of networks and relationships

6.16 This pilot recognised the importance of networks and relationships in creating a natural momentum for integration. However, delays between the original project and the decision to fund a broader roll-out showed that, without ongoing attention, networks could be diminished and momentum lost.

Scalability

6.17 The roll out of this model of care to all clinical sites in Edinburgh providing orthopaedic and stroke rehabilitative care represents one of the biggest workstreams receiving Change Fund resources in Lothian. One of the remaining questions for this workstream is the extent to which this approach could be applied to other conditions. It was reported that application of this model to other conditions would be necessary if the resource realignment was to attempt to release fixed costs. As a health service manager commented:

"*We cannot have the luxury of focusing on one or two conditions only."*

NW Perthshire - consumption fund

6.18 Perth and Kinross Council and NHS Tayside are developing the concept of a consumption fund which uses mapped data to provide a picture of consumption which would enable partners to consider:

- Whether consumption patterns are appropriate to enable achievement of objectives
- Costs per capita and whether the cost and/or the variation is appropriate and offers the best value
- Whether existing models of care are appropriate to meet the needs of the locality
- Opportunities to release resources for reinvestment to areas like preventive care, or to streamline models of care.

New requirements for provider budgets

6.19 The mechanism relies on the flexibility of provider budgets and resources to continuously adjust to changing patterns of consumption by moving resources across to maintain the right capacity in the right place and with the appropriate agency. The consumption fund concept is in the process of being tested, and Tayside partners have identified a number of challenges which will need to be overcome, for example:

- Breaking down budgets to a locality level – this is a particular issue within Health
- Development of unit costs
- Setting the right level of accountability/authorisation to transfer resources
- Frequency of monitoring dependency on the periodicity of data mapping
- Frequency of transfer of resources particularly for the third sector, which may suffer from cash flow issues.

Potential use of data warehousing

6.20 The use of data warehousing whereby each partner securely submits data files which can be accessed via dashboard software is being considered in the context of developing a live mapping tool which can be updated with appropriate frequency. A suitable data warehousing solution would be required and in addition it would be necessary to ensure that any existing data sharing protocols continue to be appropriate. This currently falls within the remit of the Tayside Data Sharing Partnership Group

Defining the scope of services in the consumption fund

6.21 This pilot is developing a consumption fund which will potentially include a range of services that extends beyond health and social care. This will build on existing networks at senior levels in the Council, for example between Environmental Services and Community Care. Frontline managers are leading local discussions with the potential to enhance local buy-in. The possibility of different models developing in different localities is acknowledged as important, given the need to harness local knowledge of service needs and the networks and relationships required to meet those needs.

Non-partisan support from elected members

6.22 It was reported that service reconfiguration is sensitive and can be readily derailed. In NW Perthshire, considerable effort has been expended to keep councillors informed about service development plans. Development days have taken place involving a wide range of stakeholders, including the police, GPs and councillors. Non-partisan support from elected members was reported to be repaying this investment of time and effort.

Highland - Lead Agency model

6.23 In December 2010, NHS Highland and Highland Council announced their decision to move towards a Lead Agency Model for Health and Social Care services. This aimed to restructure services so that NHS Highland will deliver all adult health and social care on behalf of both partners, and Highland Council will deliver some children's care on behalf of both partners. This new arrangement started in April 2012 and involves transfer of staff, buildings and budgets between the two agencies.

Evolution of integration terminology

6.24 The IRF programme is not the first time that NHS Highland and Highland Council have considered how best to use cost and activity data to inform the planning of services. Throughout the evaluation, stakeholders repeatedly made mention of similarities with the "cost cube" methodology which provided

a database of activity and cost for NHS Highland. Discussion of this dates back for almost a decade. [25]

6.25 The cost cube was acknowledged by the Scottish Government, COSLA and NHSScotland as the forerunner to the IRF mapping process. It provided a "starting point" which the IRF then developed by seeking to include local authority data on cost and activity.[26] Over the past decade, NHS Highland and Highland Council have considered a number of ways of integrating the planning and delivery of health and social care services. Discussions have used a variety of terminologies including 'aligned budgets', 'collaborative commissioning' and the 'integrated resource framework'.[27]

6.26 When the national IRF programme was launched in 2009, partners in Highland put together proposals to use the IRF funding from the Scottish Government to pilot four different approaches (see Appendix 1). However, at a joint meeting of Highland Council and NHS Highland in December 2010, partners discussed three options for more ambitious integration of services on a larger scale: single operational management; establishing a new Care Trust; and single lead agency model. Consideration of these approaches resulted in the decision to commit to introducing the third option. The lead agency model was one of the financial mechanisms promoted by the IRF programme and work on this replaced the smaller pilots.

Leadership for large scale structural change

6.27 The decision in go for large scale change resulted from negotiations at a senior strategic level within both partners' organisations. Chief Executives in NHS Highland and Highland Council showed clear and public commitment, along with political support, to proposals to move both organisations towards greater integration using a Lead Agency model. Once the decision was made public, the process of implementing it and the actions required to integrate the two services involved a much larger group of stakeholders.

Influence of IRF alongside other drivers for change

6.28 The history of discussions about potential integration between NHS and local authority partners predated the national IRF programme. The impetus for introducing a lead agency model was closely related to long term drivers such as cost pressures and demographic trends.

> *"...we are all familiar with the changing demographics of the area and the need to plan for this. Whilst the medium to longer term fiscal climate is not yet fully clear, what is evident is that if we are to meet the growing expectations our communities have of the range and quality of services we provide in the current climate, we will need to do things differently in the future. Continuing to plan and deliver services in the*

[25] http://www.highland.gov.uk/NR/rdonlyres/816BD9D1-E541-44B2-AF93-8CD5FCAEC539/0/Item21hsw11803.pdf
[26] http://www.shiftingthebalance.scot.nhs.uk/initiatives/sbc-initiatives/integrated-resource-framework/further-information-and-background/
[27] The title IRF was used in Highland in 2008 before it was adopted for the national programme.

way we currently do will not serve our local communities, nor our staff or other stakeholders, well in the future." [28]

6.29 Within this context, the national IRF programme was reported to have helped facilitate discussion on the options for integration; promoted consideration of variation in activity and cost; and encouraged partners to look at efficiency and effectiveness of resource use. Senior executives were exposed to working models of integration (such as the lead agency model in Torbay in North East Lincolnshire) through the IRF national events. This was reported to have provided valuable learning which influenced the discussion of integration options.

Commitment to addressing barriers

6.30 The experience in Highland has highlighted the variety of ways in which the two partner organisations are different (e.g. different planning cycles and different political accountability). The differences in accounting systems - which were noted by all sites during the IRF mapping – were shown in stark relief in Highland where moving staff, buildings and resources has encountered additional challenges such as:

- Different legal requirements for dealing with aspects of VAT
- Different systems for paying employees (including different pay periods)
- Different terms and conditions for staff (holidays, qualifications and remuneration)

6.31 NHS Highland and Highland Council have undertaken significant work to address these issues. They have shown strong commitment to integration and have, where necessary, developed temporary solutions to these problems in order to avoid delays to the introduction of the Lead Agency model.

Structural change and measurable change in costs and outcomes

6.32 Highland is undergoing large scale structural change which will require time and effort to implement. It was reported that service continuity is a key priority during the transition to the lead agency model. The new approach may provide opportunities to consider reallocation of resources in a more integrated way and should remove any perverse incentives for cost-shunting between partners. However, it was reported that structural change will take time to implement and partners expect that significant changes in outcomes or costs are unlikely to be achieved in the short term.

Key findings

- Progress with trialling new models of integrated working was linked to existing knowledge of the services and of realistic appraisal of the extent of partnership. Pilots reported the importance of balancing the funding level and timescale

[28] The Highland Council / NHS Highland: *Improving Joint Service Delivery – A new Partnership Model.* Joint report by Chief Executive the Highland Council, and Chief Executive NHS Highland (16th December 2010).

alongside local drivers and barriers in order to define realistic opportunities for better integrated working.

- The commitment at a strategic leadership level from Chief Executives in NHS Boards and in Local Authorities was important where large scale integration was considered. Non-partisan support from elected members was also reported to be valuable and worthy of investment.
- The test sites recognised the importance of networks and relationships in creating a natural momentum for integration. When introducing new models of working the test sites encountered a number of barriers and used strong relationships and a shared commitment to create solutions or work around these problems.
- The test sites reported the value of work amongst partners to articulate and understand the shared aims and outcomes that gave purpose to integration. It was acknowledged that variation in perceptions of risk could undermine this.

7 LESSONS FOR FUTURE INTEGRATION

7.1 One of the main aims of the IRF evaluation was to draw out implications from the findings to inform other partnerships. This included identifying lessons that may help with future moves towards financial and resource integration, both within and across health and social care services, in Scotland. Chapters 3, 4, 5 and 6 address this by drawing key findings from the test sites' experiences of undertaking IRF mapping and trialling new models of integration. This chapter pulls together an analysis of three themes (purpose, scope and drivers) which have more general application to the emerging integration agenda.

The purpose of integration

Defining the benefits of integration

7.2 The IRF aimed to inform partners of how resources are currently spent on delivery of health and social care services, enabling them to make better use of these resources in the future. To meet this aim, the Scottish Government designed the IRF programme with two key stages: mapping of health and social care data; and trialling new integrated ways of working. As the test sites undertook these two stages, partners developed individual definitions of the function of the IRF to suit their local situation. For some it was a philosophy of partnership working that underpinned future service development; for others it was a pilot initiative that provided a catalyst for trying something new; and for others it provided an opportunity to revisit previous initiatives in partnership working. The range of interpretations of the IRF helped stakeholders to accept it as relevant to their area of work but also blurred the lines between the IRF and any other forms of integrated working.

7.3 When the evaluation baseline was carried out in 2010, partners reported that the IRF was aiming to affect outcomes which would directly impact on the delivery of services (such as improved efficiency, cost savings, better quality of care, and empowered staff). However, as the evaluation was repeated in 2011 and then again at the start of 2012, the expectations of the IRF were described in terms of process outcomes (such as opening up discussion, improving dialogue, raising awareness and improving information). This shift reflected the experience of the test sites, which indicated that integration does not happen at the flick of a switch but rather as part of an ongoing process of change. Partners reported that process outcomes may - or may not – lead to more tangible outcomes such as more efficient use of resources or a measurable improvement in patient care.

Evidencing the benefits of integration

7.4 In 2009, the Scottish Government commissioned a review of international literature on the financial and resource mechanisms used to integrate care. The report of that work found that many countries are "*endorsing partnership working in order to design provision around users' needs*". However it also noted that it is "*difficult to provide clear messages about (integrated resource*

models') effectiveness" and that "*evidence on critical success factors tends to be anecdotal*".[29]

7.5 The IRF evaluation confirmed this finding, namely that making the case for integration is intuitively simple but evidencing and implementing integration is practically complex. Partners repeatedly reported that intuitively it is "*impossible to argue against the potential of integration*" and "*if you were designing services from scratch you would automatically create a more integrated way of doing things*". However, it was also consistently stated that the historical position is one where care is provided by a number of different agencies and organisations and weighted towards institutional settings rather than community care. Partners reported that leadership and legislation are likely to be needed to overcome the inertia inherent in this historical position.

7.6 Some stakeholders noted an apparent circularity between the need for evidence of the benefits of integration as the basis on which to build a case for implementing it and the need to implement integration in order to evidence the relative benefits. The IRF made some progress in addressing this "chicken and egg" dilemma by increasing the awareness of the value of more integrated mapping information across the test sites and within the pilots. However, the IRF test sites are only now beginning to try out new financial mechanisms under real conditions of use so the evidence base for the benefits of integration remains limited.

Understanding stakeholder expectations

7.7 It was reported that a service change that results in community delivery with a focus on enabling greater independence can, initially, be interpreted as service withdrawal and that the benefits are not always immediately clear to service users or the public. For example better coordination of services may result in fewer staff being required to deliver care but this can be interpreted by the recipient as a reduction in care. A natural predisposition on the part of both the public and staff to stick with what they know, and concern about risks in making changes to the care of vulnerable people, were reported as significant factors in inhibiting a shift in the balance of care.

7.8 Test sites reported that it can be difficult for service users and the public to accept that a change is either necessary or beneficial. Public perceptions were reported to be an important consideration where integration aimed to implement service change - particularly where a long-standing package or service arrangement has been in place - with limited evidence that current services are not working and therefore need 'fixed'. Fear of loss of services and scepticism about the motivation for change (cost-cutting rather than patient benefit) were reported to impact on perceptions of both the public and staff involved.

"Some families feel they have fought for years to get service and worry that if they agree to reduce or give up, how will they get it back if

[29] Weatherly, H. et al 2009 *Financial integration in health and social care: Evidence review.* Scottish Government: Edinburgh.

needed? It's all about good relationship and trust between families...and providers."

7.9 Expectations about what care should be available, where it should be provided and how quickly it should be accessible combine to influence the level of demand for health and social care services. A better understanding of the different perception of need held by the public, patients, professionals, planners and politicians could provide greater momentum for future work on integrating care.

Demonstrating leadership commitment

7.10 Two complementary attributes were reported to differentiate the extent to which local leaders were able to facilitate integration: clarity and commitment. As discussed above, clarity and agreement on definition of the expectations, benefits and outcomes of integration is essential. However, the experience of the test sites indicates that clarity of purpose must be matched by leadership commitment in order to create the momentum required to effect change. Strategic leadership commitment was signalled by:

- the level of seniority of individuals representing organisations at joint meetings
- the regularity of attendance by individuals (rather than sending apologies or a deputy)
- the ease with which joint meetings had represented authority to make decisions
- willingness of senior staff to take active roles in trialling new models rather than restricting their involvement to strategic planning or steering groups.

7.11 Integration was driven more quickly when there was clear leadership commitment at a Chief Executive level in both partner organisations. This was found to be useful in defining the parameters for integration and encouraging an integration culture. However, strategic direction was also notable where its absence left a vacuum in which partners struggled to make real progress.

The scope of integration

A whole system approach to health and social care

7.12 The IRF aimed to support improvement in the provision of health and social care by considering the combined resource and activity of NHS and Local Authority partners. Analysis of the mapping and trialling of new models carried out by the test sites indicated that integration would benefit from a whole system approach which would include a wider range of services (e.g. housing and education).

7.13 The IRF test sites talked of integration within the three broad areas of anticipatory care, treatment and rehabilitation. However it was reported that integrated systems need to make stronger links across these elements of care and also complete the cycle by including prevention (via public health promotion), and palliative care. In particular, it was also acknowledged that the level of demand for care needs to be considered earlier on and that the

promotion of healthy lifestyles and reduction of unhealthy behaviours could have a significant role to play in controlling the level of demand required of an integrated health and social care system. Stakeholders reported that addressing problems such as alcohol and drug misuse, smoking, diet and exercise should be included in the analysis and planning of integrated care.

Complementary large and small scale integration

7.14 The experience of the test sites indicates that some form of large scale integration of budgets would be needed in order to address big financial items such as fixed costs and resource realignment. Stakeholders involved in the pilots reported limited opportunity or value in working on integrating small localised budgets without the freedom created by a much broader look at freeing up the entirety of resources of all partners.

7.15 However, the evaluation found that smaller scale integration would also be necessary within this to make manageable the network of partnership relationships and understand the needs of natural population groupings - *"It's down to people knowing each other"*. The smaller scale integration would focus on care delivery based on geographic settings (e.g. districts or localities), care pathways (e.g. stroke rehabilitation), or care groupings (e.g. young people with complex needs).

Replicating local innovation on a larger scale

7.16 Some of the test site pilots created positive examples of service review and identified opportunities for improved integration. However, there was little evidence of work piloted in one area being rolled out or copied in other areas. Even pilots within a single NHS board, but involving only one Local Authority partner, reported that the same ways of working would not necessarily be copied by neighbouring councils within an NHS board without a similar piloting phase to test if the lessons were transferrable. Local innovation was therefore seen as creating useful case studies of the potential of change but was limited in the extent to which it impacted change on a wider scale.

Long term commitment to overcome short term challenges

7.17 There was no legal requirement to integrate, which meant that partners in each of the test sites were able to work to their own timescales. There was significant variation in progress across the pilot sites depending on the drivers, enablers, inhibitors and barriers (discussed later in this chapter). There was a consistent message from the test sites during each of the three rounds of evaluation that the timeframe for introducing integration needs to reflect the complexity of the process and the difficulties in getting the main stakeholders fully engaged.

7.18 The evaluation found evidence of a number of potential short term downsides to integration which would have to be accepted and then addressed before longer term benefits could be realised:

- The process of implementing change may incur additional costs in the short term which have to be balanced against the likelihood of making greater efficiencies or potential saving through integrated services in the longer term.
- The process of implementing change may disrupt services in the short term as providers and users learn new ways of delivering and receiving services. However, in the longer term, integrated care pathways could simplify services.
- The process of implementing change may unsettle public and patient expectations especially where they involve apparent cost cutting measures. However, in the longer term, integrated services have the potential to increase satisfaction by demonstrating improvements in outcomes and better value for money.
- The process of implementing change may increase workload pressures or job uncertainty for staff in partner organisations in the short term. However, in the longer term integrated working may lead to more efficient use of staff time across the system.

7.19 If future integration initiatives are to move beyond process outcomes and start to deliver impact outcomes then longer timeframes need to be considered. The legacy of delivering institutional-centred care via separate organisations means that time will be needed to disinvest resources and free up fixed costs (e.g. revise staffing levels and the use of buildings).

The drivers of integration

7.20 The evaluation identified two categories of drivers which could build momentum for change or act as barriers which made progress more difficult. These drivers are differentiated by the level of control that can be exerted over their direction and impact. The first category comprised of systematic levers for change over which an element of proactive control could be exerted. The second category comprised environmental and cultural drivers over which control was more limited and reactive.

Systematic levers of change

7.21 The table below lists five key levers which were found to strongly influence changes in behaviour of partners at all levels. If these are considered and controlled then they hold the potential to enable positive change. However, ignoring any one of these could turn it into a barrier.

Lever	Potential to act as a driver	Potential to act as a barrier
Policy and legislation	• Consistent policy direction can encourage partners to commit to greater integration of services. • Consistent policy direction can promote shifting the balance of care from institutional to community settings.	• Specific policies emerging over time can lead to uncertainty about what the next change will be. • Too many policy initiatives and pilots can dilute the ability of stakeholders to participate in each.
Systems and structures	• Changes to governance arrangements can coordinate services and facilitate greater integration (e.g. co-location, shared assessments) • Changes to financial mechanisms can allow integrated planning of budgets and facilitate transfer of resources between organisations.	• Reorganisation of systems and structures takes time and effort to implement and can disrupt services during the transition. • Repeated reorganisation of systems or structures can lead to uncertainty about how long any organisational structure will last.
Information	• Analysis of data from partners can provide a more complete picture of service delivery to inform planning decisions • Mapping information can inform analysis of variation in service provision.	• Mapping information can focus planning decisions on what can be measured - which may not necessarily be what is important. • Uncertainty about the validity and use of mapping data can lead to disengagement and confusion.
Incentives	• Financial incentives can be used to encourage changes in service delivery. • Reward frameworks such as the QOF can be used to standardise changes in service delivery.	• Financial incentives can skew attention on particular areas which may be at the exclusion of newer and more innovative ways of working. • If some partners receive incentives to engage in integration but others do not then this may seem unequal.
Improved outcomes	• Potential improvements to the efficiency, effectiveness and equity of provision can encourage sharing of information and resources. • Potential improvements to the quality of services and to patients' experience of care can encourage partners to consider integrated ways of working	• Competing or conflicting objectives can act as a barrier to integration. • If the improved outcomes are not communicated to stakeholders or accurately measured over time then partners may lose interest as change is perceived to become an end in itself.

Environmental influences

7.22 When the IRF programme started there was some concern reported amongst stakeholders that the wider economic environment might cause services to retreat into a culture of protectionism rather than take a perceived risk on sharing budgets more openly with partners. However, over the evaluation

period, there has been a marked shift towards acknowledging that external financial pressures make it more difficult for partners to continue to provide services in the same way. This has encouraged partners to consider the potential of new more integrated ways of working.

7.23 Demographic trends were reported to act as a key driver for integration within and across the test sites. Impetus for new ways of working has arisen from the challenge of attempting to provide quality care that meets the increasing needs of an aging population within an economic climate of limited public spending. This has been accompanied by a consistent policy agenda of "s*hifting the balance of care"* and supported by specific programmes such as the IRF and the Change Fund. Cost pressures and future demographic and care trends were reported as providing partners with an increasing motivation to change current models of service delivery.

7.24 It was noted by partners throughout the evaluation that the level of demand for health and social care services was growing. This was due not only to the demographic pressures of a population that is living longer with increased health and social care needs, but also linked to factors such as smoking, drug or alcohol misuse, obesity and mental health issues. It was widely reported that the benefits of providing more integrated services for one group in the population were not always easily identifiable, since the level of demand from other groups transferred to fill any slack in provision. Changes in these demand pressures could incentivise changes to provide services in new ways to keep up with need.

Conclusion

7.25 The IRF helped enable four NHS Boards and 12 Local Authorities to gain a clearer understanding of health and social care costs and activity. It has identified some of the limitations of current data, but also started to address some of these through national support of local innovation.

7.26 The IRF encouraged partners to experiment with new ways of jointly planning services and delivering care. Over the past two years, it has supported national policy direction to shift the balance of care and has contributed to the development of a growing culture of more integrated service delivery. Implementation of new financial mechanisms to facilitate resource transfer proved a lengthier undertaking than expected and the value of new financial models is not yet fully developed or tested in Scotland.

7.27 The evaluation has identified and reported on a broad range of lessons from the test sites. In particular, the IRF has shown the importance of: (i) clear definition and communication of the purpose of integration; (ii) sufficient scope, scale and time for integrating services; and (iii) understanding and harnessing all available drivers to engage stakeholders and deliver change. This learning should inform further development of the IRF and may well be relevant in the consideration of the emerging policy and legislation about the future integration of health and social care services.

8 RECOMMENDATIONS

8.1 Local and national partners should examine the lessons from the IRF test sites and learn from this to improve the alignment of policy direction, planning structures, financial mechanisms, and mapping information. Failure to address all of these may result in unnecessary barriers to integration. It will be important for the Scottish Government and its partners to ensure that the learning from the IRF test sites and this evaluation inform legislation that will introduce the development of new Health and Social Care Partnerships.

Policy development

8.2 The Scottish Government is currently consulting on proposals to improve outcomes by better integration of adult health and social care based on four key principles:

- Nationally agreed outcomes will be introduced that apply across adult health and social care;
- Statutory partners will be jointly accountable to Ministers, Local Authority Leaders and the public for the delivery of those outcomes;
- Integrated budgets will apply across adult health and social care; and
- The role of clinicians and care professionals will be strengthened, along with engagement of the third and independent sectors, in the commissioning and planning of services.[30]

8.3 The proposals outlined by the Scottish Government consult on many of the issues raised in the IRF evaluation and point to greater clarity and commitment in the delivery of integrated services. The following two recommendations would support the proposals by encouraging synergy across policy areas and promoting communication with the public as a central tenet of service change.

Recommendation 1. In order to support the implementation of its proposals for integrated adult health and social care, the Scottish Government should develop an integration assessment tool. This would provide a standard checklist of questions to be used by national and local partners to review current and future policies and strategies on individual service priorities (e.g. cancer care, delayed discharge, self directed support, and palliative care).

Recommendation 2. The Scottish Government should work with NHS Board and Local Authority partners to develop consistent national and local communication strategies to better engage and inform the public about the anticipated benefits of new ways of delivering integrated health and social care services.

Planning structures

8.4 The Scottish Government should work with COSLA, the Royal College of Physicians, The Royal College of GPs, The Royal College of Surgeons, NHS

[30] www.scotland.gov.uk/Publications/2012/05/6469

Boards and Local Authorities to consider how future planning structures such as the introduction of HSCPs can address the issues raised in this report. The following three recommendations focus on incentivising engagement, improving representation, and providing training.

Recommendation 3. The Scottish Government should work with NHS Boards and Local Authorities to examine how the potential for improved patient outcomes, increased professional standing, financial rewards, and workload balance can be used to create incentives for health and social care professionals to engage more fully in the development of integrated health and social care services. The first step in addressing this should be to review current contractual arrangements for GPs, hospital clinicians and social care service managers in order to check that these reflect the prioritisation of integrated working. Broader engagement would also be facilitated by ensuring appropriate support for professionals with direct patient/client service delivery commitments to attend relevant meetings.

Recommendation 4. The Scottish Government should work with partners to develop guidance for the formation of HSCPs and locality planning arrangements which includes:

- an approach that ensures that professionals and staff are effectively included in service planning and commissioning;
- effective local engagement structures to expand awareness and involvement beyond those directly involved in HSCP meetings;
- clear and appropriate levels of delegated decision-making.

Recommendation 5. The Scottish Government should work with NHS National Education for Scotland (NES) and Scottish Social Services Council (SSSC) to support all those involved in new HSCPs and locality planning structures so that partners have the necessary skills and knowledge to:

- analyse information on cost, activity and quality;
- evaluate and prioritise care options;
- negotiate complex partnership decisions in the context of strategic joint commissioning.

Integrated information

Recommendation 6. The Scottish Government should continue the process of sharing lessons from the work in the IRF test sites on patient-level mapping with other partnerships, giving consideration to the level of detail which should be shared. Test sites which have positive examples of analysing and using IRF mapping information should consider ways in which these could be written up or shared more widely in order to allow other areas to learn from this work. Links to documents on a centralised webpage may offer the simplest way to facilitate this.

Recommendation 7. The Scottish Government, ASD and ISD should work with NHS Boards and Local Authorities to prioritise the information gathered and simplify its presentation. This should aim to increase the efficiency with which mapping data can be produced, and the ease with which it can be compared - although a degree of local flexibility could remain valuable. A standard patient-level costing methodology

should be applied by local costing groups consisting of NHS Board and Local Authority partners.

Recommendation 8. The Scottish Government, ASD and ISD should work with local partners to find ways of addressing the following four data limitations identified by the IRF:
(i) The concerns of some GPs about sharing Community Health data which accounts for about one fifth of total health and social care expenditure.
(ii) The need to involve additional partners whose work has an impact on health and social care (e.g. education and police departments).
(iii) The need to include quality and outcome measures alongside cost and activity data.
(iv)The possibility of extending analysis to include: public health activity (in key areas such as obesity, mental health, alcohol, smoking and drugs); demographic pressures; and future cost implications based on assumptions about cost of illness.

Recommendation 9. The Scottish Government should create guidance on how improved mapping information could be proactively shared with a wider range of stakeholders - including service providers, service users and the public - to examine unwanted variation, improve outcomes, and increase efficiency. NHS Boards and Local Authority partners should then use this guidance to proactively engage with a wider range of stakeholders on a regular basis.

Financial mechanisms

8.5 The limited evidence from the IRF evaluation indicates that where integrated working has led to more efficient use of resources this has not resulted in cost savings or the transfer of resources to other parts of the health and social care system. The evidence from this evaluation indicates that joint commissioning arrangements will require a specific focus on the release of fixed costs. Further work is needed to examine the opportunities for addressing fixed costs and the possibilities for releasing savings.

Recommendation 10. The Scottish Government should work with the IRF test sites to evaluate the new financial mechanisms which are now being introduced. This should seek to quantify the level of efficiencies created and analyse whether these result in improved services being delivered for the same level of cost, or in cost savings which can be released from the system altogether.

Recommendation 11. The Scottish Government should facilitate a series of workshops with NHS Boards and Local Authorities to develop a better understanding of fixed costs, and how these limit improvements in the planning and delivery of health and social care services. The Scottish Government should also produce a national briefing document on fixed costs which includes:

- the components of the costs of care with discussion on the extent to which these are fixed or variable
- options for making fixed costs more variable (discussing the pros and cons of each option)
- examples of successfully addressing fixed costs to improve services.

APPENDIX 1. LIST OF PILOT PROJECTS IN THE TEST SITES

Ayrshire and Arran

East Ayrshire: adults with complex needs

The East Ayrshire IRF pilot focused on researching the individual elements of care provided to adults with complex needs. The pilot looked to better understand and describe: the profile of clients within the target group; the range and cost of services provided for the target group; and the provision of joint commissioning of services for the target group. The research produced twenty one high impact recommendations which were developed into a joint action plan for implementation.

North Ayrshire: children with complex needs

The North Ayrshire pilot looked at services delivered to young people with complex needs. The pilot used half day stakeholder events to examine three options: Locality Planning; Integration of Psychology Services; and Integrated Care Pathways for Children with Complex Needs. It analysed resources used by 60 children with complex needs across the three CHP areas. However, the short timescale of the pilot made it difficult to recruit a project manager for this work and progress was slow. Once a member of staff was identified, an action plan was created and this is now being implemented.

South Ayrshire: older people's services

The aim of the South Ayrshire IRF pilot was to use the IRF to facilitate the shifting of the balance of care (SBC) for older people in South Ayrshire and to support the associated shifting of resources. The original approach of the IRF pilot was to consider a system-wide piece of work looking at resources and activity. However, due to the limited timescales for delivering the IRF pilots, the system-wide approach was refocused on four key strands which were more bounded and more easily measured: re-ablement; day services; falls prevention; and hospital discharge.

Pan-Ayrshire: Chronic Obstructive Pulmonary Disease services

The COPD pilot involved work across all three CHPs to improve the COPD service by exploring more integrated pathways which incorporate the principles of self-management – currently being developed within the Co-Creating Health programme. Across all three areas the pilot looked at the use of single shared assessments, care coordinators, Anticipatory Care Planning (ACP), multi-disciplinary working and self-management training.

Highland

Lead agency model

NHS Highland, Highland Council and Argyll and Bute Council initially considered developing local pilots to examine four different financial mechanisms: (i) NHS Board area strategic pilot looking at the total resource applying to the over 75 year old population; (ii) District pilots examining more flexible use of a joint financial envelope for a more local population; (iii) small local examples of change with a focus on innovation (e.g. virtual wards); and (iv) lead commissioning on a pan Highland basis for a single service (e.g. Occupational Therapy). In December 2010 NHS Highland and Highland Council took a decision to commit towards large scale integration using

a lead agency model (see Chapter 6). In light of this the pilots were discontinued or subsumed within implementation of lead agency arrangements.

Lothian

City of Edinburgh: Phased implementation of orthopaedic and stroke rehabilitation pathways
The project aimed to shift the balance of care within stroke and orthopaedic rehabilitation pathways, and to achieve a greater proportion of active rehabilitation of patients outwith hospital settings. It focussed on older people, although not exclusively 65+, living in the City of Edinburgh.

East Lothian: Community Based Services for Older People
The pilot covered the East Lothian Council and CHP area. The target population was older people, including adults over 65 years with long term conditions, people with dementia, and adults across all care groups who require support in caring for themselves. The project aimed to develop community services in order to reduce hospital admissions for older people, thereby shifting the balance of care from hospital and residential settings to the community. Hence individuals with increased needs will be able to remain safely at home for longer.

Mid Lothian: Community Based Care and Treatment for Older People
This pilot covered the Midlothian CHP area. There were two target populations: the 500 people with dementia known to, and diagnosed by GPs; and those members of the frail, elderly population at significant risk of requiring hospital admission due to long term conditions. The project aimed to develop community-based services and improve joint working in order to reduce reliance on long-stay care homes and continuing care beds, and minimise admissions to, and length of stay in, acute hospitals.

West Lothian: Early intervention and follow-up of substance misusing parents and their children
The target population was children under 5 living in households where parents are misusing substances, particularly at the pre-birth stage. In 2009, 19 new clients, involving 30 children, reported to the Scottish Drugs Misuse Database in Armadale and Blackridge (areas with high levels of socio-economic deprivation measured by data zones ranked by deprivation).[31]

Note: During 2011, in light of the Change Fund focus on older people, the decision was taken by West Lothian IRF project team members to change the focus of their IRF work to older people.

[31] Note: During 2011, in light of the Change Fund, West Lothian IRF project team decided to change the focus of the pilot to older people.

Tayside

Perth and Kinross: Development of a locality model and consumption fund for Highland Perthshire

Work being pursued by Perth and Kinross Council and Perth and Kinross CHP under IRF aimed to reshape older people's services in line with: the roll out of the re-ablement model; personalisation; housing with care; early intervention and prevention; care at home; and implementation of the Virtual Ward project. The geographic area covered by the proposal was Highland Perthshire, with a focus on the over 65 population, but with benefits also being realised for the under 65 adult population, for example in the area of learning disabilities. The proposal was not restricted to one service, but rather aimed to work towards a transformational health and social care service within this area.

Dundee: Working with frail older people and those with complex needs in Dundee East

Work pursued under IRF by Dundee City Council and Dundee CHP in Dundee East locality focused on older people who were frail or had complex needs and aimed to: provide scaled up and integrated enablement and virtual ward services in the context of the integrated service framework for older people; and to provide quality/sustainable services that enable people to maintain an independent lifestyle. It did this by: increasing the proportion of AHP staff, currently working in inpatient settings, to more community-based work; increasing the proportion of the AHP role devoted to education and prevention; increasing the number of staff working in enablement in order to spend less on care homes, spend less overall and spend less per person; increasing the number of anticipatory hybrid staff; and increasing carer engagement, volunteer resilience and use of the voluntary sector.

Angus: Development of a fully integrated locality model for adult care

The Angus Partnership proposed to develop a fully integrated locality model for the delivery of adult care. Work proceeded in the following areas: care and case management; enablement and rehabilitation; workforce development (new roles and training); shared accommodation/co-location; and the development of Telecare and Telehealth.

APPENDIX 2. COMPONENTS OF THE DIFFUSION OF INNOVATION MODEL FOR COMPLEX INNOVATIONS IN HEALTH SERVICES

1. Material properties of the IRF
To be successfully and widely adopted, the IRF must include key functionality and work smoothly and efficiently under real conditions of use.

2. Attributes of the IRF as an innovation
To be successfully and widely adopted, the IRF must be seen by potential adopters as having:

- Relative advantage (that is, clear benefits over existing technologies)
- Simplicity
- Compatibility with existing values and ways of working
- Trialability (can be tried out on a limited basis "without obligation")
- Observability (benefits can be seen directly)
- Potential for reinvention (capacity for users to customise and adapt it)

3. Concerns of potential adopters
Adoption is a process, not a one-off event, and is influenced by concerns, including:

- Before adoption - what are its properties and potential benefits? What will it cost me?
- During early use - how do I make it work? When and how should I use it?
- During established use - how can I alter or improve it?

4. Communication and influence
A person's decision to adopt an innovation is influenced by:

- Mass media (press, mail shots), which can raise awareness
- Interpersonal influence (by champions, opinion leaders, for example), which can change people's attitudes towards adoption

5. Organisational antecedents for innovation
Organisations may be more or less innovative. Differences are explained by several factors:

- Absorptive capacity for new knowledge
- Leadership and management
- Risk taking climate
- Effective data capture systems
- Slack resources

6. Organisational readiness for innovation
An organisation must be "ready" for a specific innovation. Readiness includes:

- Innovation-system fit
- Tension for change
- Balance between supporters and opponents
- Specific preparedness

7. The implementation and routinisation process
Implementing a complex innovation, and making sure it becomes business as usual, is a highly non-linear process, typically characterised by shocks and setbacks. Critical success factors include:

- Appropriate change model (balance between “make it happen” and “let it emerge”)
- Good project management
- Autonomy of frontline teams
- Human resource factors, especially the selection, retention, continuity, and training of staff
- Alignment between new and old routines

8. Linkage
Innovation is more likely when there is:

- Early and ongoing dialogue between the developers of the innovation, the change, agents charged with promoting its adoption, and the end users
- Communication within the organisation and between similar organisations

9. The wider environment
Innovation in organisations is more likely when a “following policy wind,” a conducive socio political climate, and specific incentives and mandates at national level are present

(Adapted from Greenhalgh T, Robert G, Macfarlane F, Bate P, Kyriakidou O. Diffusion of innovations in service organisations: systematic literature review and recommendations for future research. Millbank Q 2004;82:581-629.)

APPENDIX 3. CHECKLIST FOR SHARING MAPPING DATA

The level of detail and length of discussion should be matched to the audience with whom the mapping information is being shared. The following ten point checklist was developed to address the key problems reported by test sites in their attempts to engage a wider range of stakeholders:

- Is the purpose of sharing the data clear and agreed?
- What role can the data play in achieving this?
- What can be learned from local experience of presenting data to this type of audience?
- Which data should be presented?
- Apart from the data, what else should be presented or discussed?
- How much data should be presented?
- How accurate do the data have to be?
- How might the audience react to the data presented to them?
- How can negative reactions be anticipated and addressed or minimised?
- What are the next steps following the presentation of data?

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