The Scottish Government

Integrated Resource Framework for health and social care

1. Introduction

The Integrated Resource Framework (IRF) for health and community care is under development as part of our focus on Shifting the Balance of Care. Its purpose is 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 programme is being developed jointly by the Scottish Government, NHS Scotland and COSLA. Work on the IRF began in 2008. A locally developed model - the Cost Cube - from NHS Highland, provided a starting point, with further development taking place to develop an understanding of the relationship with some of Highland Council social care activity and cost.

Key to the IRF is the principle that, in order to make best use of available resources, partnerships need to:

1. understand the costs associated with the activities they plan for, invest in and deliver across the entire resource spectrum; and
2. examine variation in practice and outcomes for patients and service users in different localities.

By providing Health Boards and their Local Authority partners with the information required to plan strategically and review services more effectively, and by developing financial relationships that integrate resources around populations instead of organisations, partners will be able to realign their resources to support shifts in clinical/care activity within and across health and social care systems. Examples of early emerging analysis from the IRF work are provided in Annex A. Further background on the philosophy underpinning the approach is provided in Annex B.

It is important to note that the IRF is *not* just a tool for Finance Departments - instead it focuses on clinicians and care professionals and the decisions they make that commit resources and determine outcomes for patients and service users. Structures and systems are required that ensure professionals are operating with a fuller understanding of their environment and the ramifications of their decisions, and are consequentially accountable for their decisions and actions. There is clear international evidence that more effective integration improves people's experience of services, and enable better models of care to be provided without necessarily incurring additional cost.

2. Progress to date

The IRF development process has two main components:

- *Phase 1:* Explicit mapping of patient and locality level cost and activity information for health and adult social care, to provide a detailed understanding of existing resource profiles for partnership populations;
- *Phase 2:* Implementation of agreed and transparent mechanisms that allow resource to flow between partners, following the patient to the care setting that delivers the best outcomes.

Phase 1 - Mapping

Over the last year most Health Boards, some with their Local Authority partners, have started to apply the IRF approach by mapping their entire resource use and activity to patient and locality level.

Phase 2 - Mechanisms

Four test sites are taking forward the second phase of the IRF. These sites are focusing on selected populations of interest (either geographically or care group defined), and they will develop and implement mechanisms for shifting resources both within the NHS, and between the NHS and local authority partners, to achieve improved outcomes for their populations. The test sites (4 Health Boards and 12 Councils) are:

- 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.

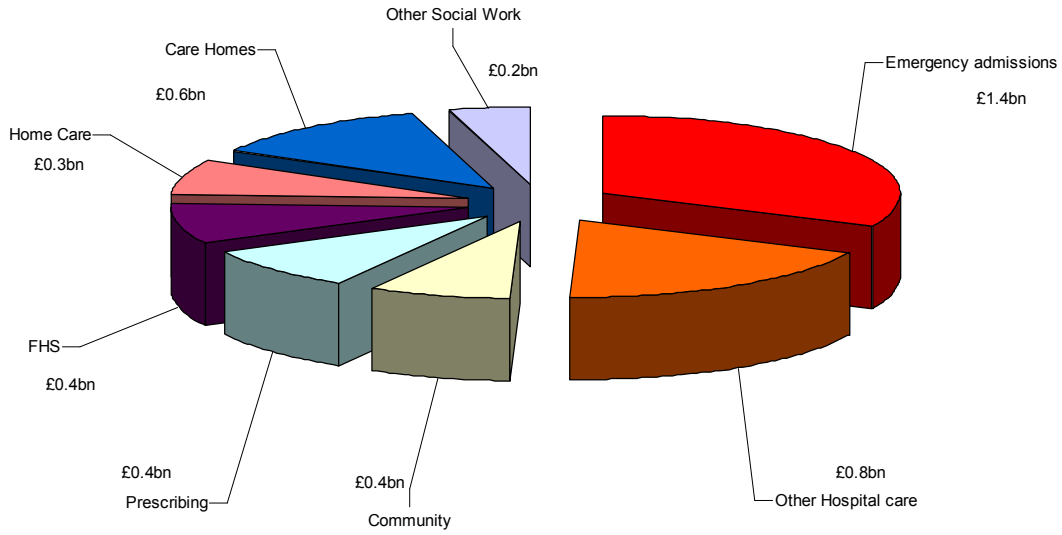
The test sites are now starting to implement the IRF - identifying their population(s) of interest; collecting the mapping data; identifying the integrator; and considering which financial mechanisms to use to move resources. The revised arrangements will go live in April 2011. We are in the process of discussing milestones and timescales with the test sites to assure the April 2011 date, and it will be important that the test sites' efforts are committed to the challenges already identified over that period to ensure progress. We are particularly aware of the cultural and organisational demands of the programme – establishing the analytical evidence is a vital first step, but real improvement will only be delivered if the test sites successfully use that data and new financial relationships to challenge and change current practice.

An action-learning based evaluation of the test sites has been commissioned and begun, concluding in November 2011. The purpose of the evaluation is to contribute to the process of change and determine the effectiveness of the approach. We have established a learning network for the test sites, which includes the evaluators, and which will help to share good practice between and beyond the test sites as the work is underway.

Annex A - Sample analysis

The following examples of analysis generated by the IRF mapping work (Phase 1) so far are provided to illustrate the opportunities this type of data can provide for professional discussion around the ramifications of decision making in terms of resource allocation and outcomes for people.

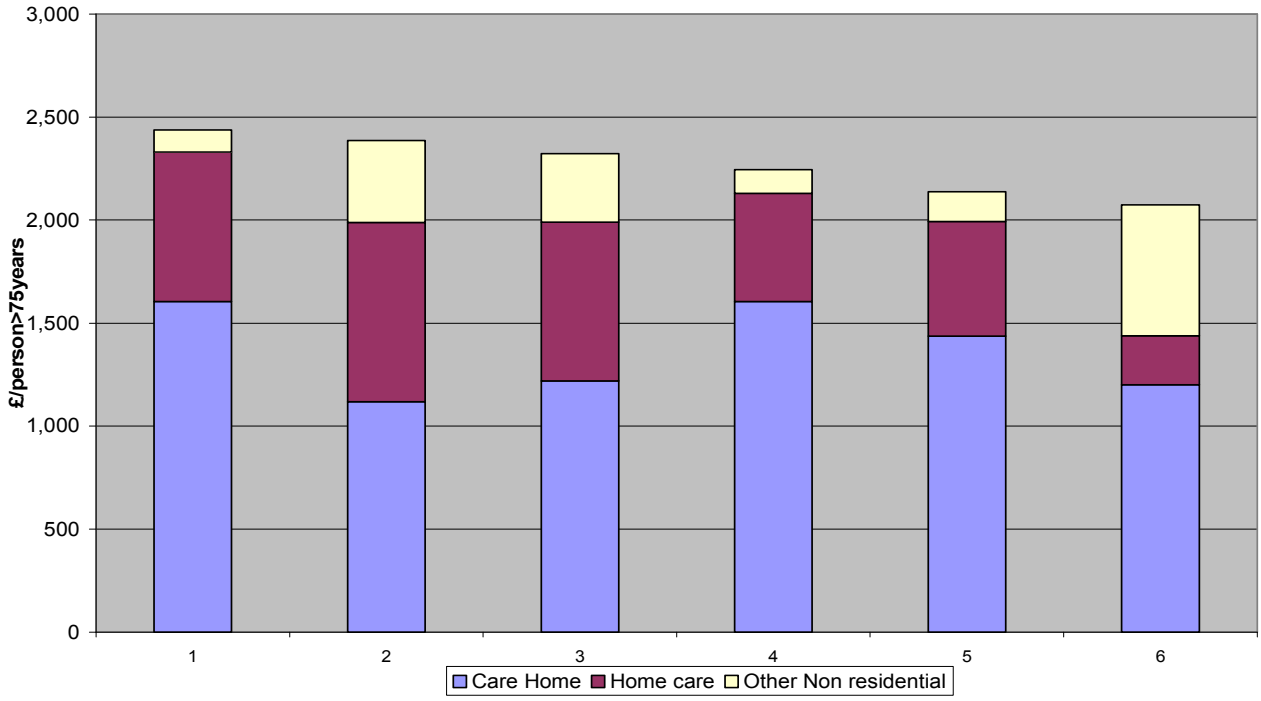
Figure 1: Health and Social Care Expenditure – Scottish Population aged 65+ (2007/08, total = £4.5bn)



Points to note:

- Nearly one third of the total spend - £1.4bn out of the total £4.5bn is accounted for by unplanned emergency admissions to hospital – a huge area of unplanned, reactive spend, which, it is widely recognised, often does not deliver the best outcomes for older people;
- More was spent on unplanned emergency admissions to hospital for this age group than the entire older person's social care budget - £1.1bn in 2007/08.

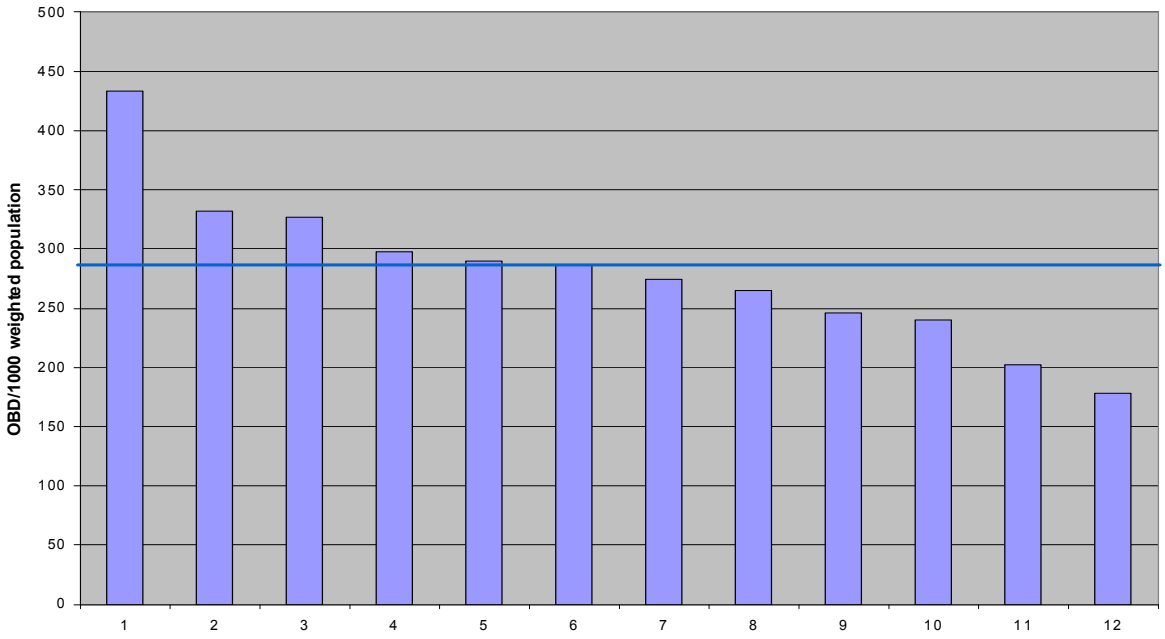
Figure 2: Local authority older persons social work expenditure for 75+ population - across 6 CHPs covering 2 Health Boards and 2 local authorities



Points to note:

- There is noticeable variation both in terms of spend per head and the profile of the spend itself, especially in light of our policy commitment to keep older people safe and well and as independent as possible, in their own homes, for as long as possible. This evidence is congruent with the results of SWIA's 2010 *Improving Social Work in Scotland* review, and also the outcomes of the 2008 Multi Agency Inspection of Older People's Services in Tayside and Forth Valley.

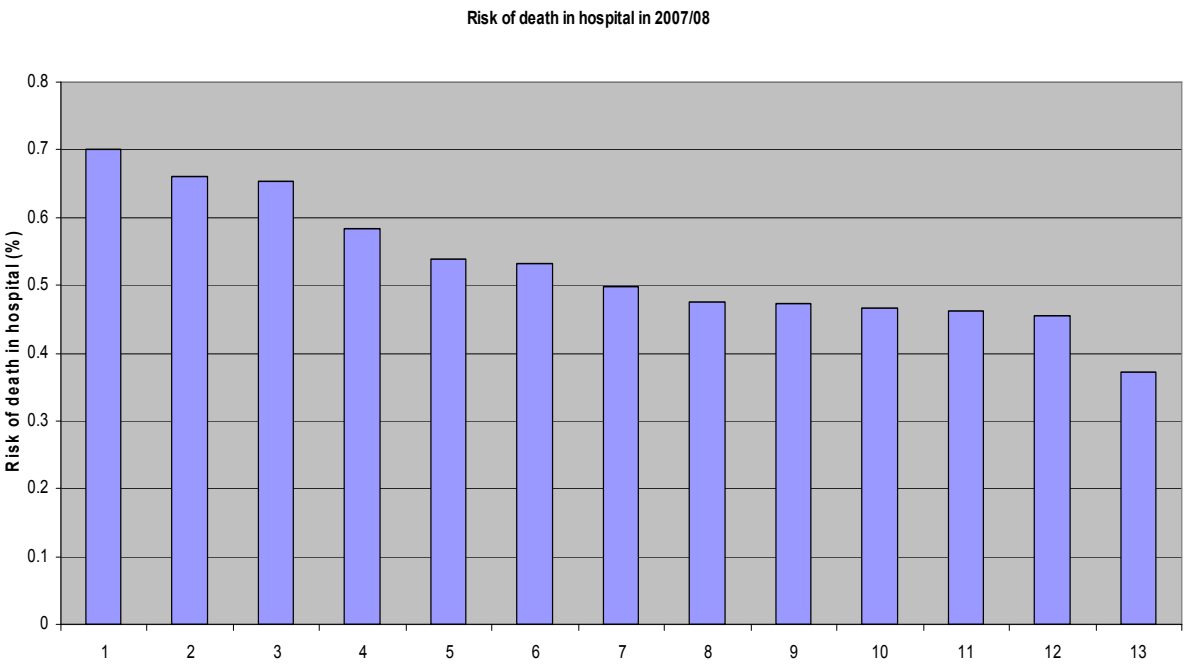
Figure 3: Acute General Hospital Occupied General Medical Bed Days, by GP practice (average 2006/07 – 2007/08)



Points to note:

- Material variation in terms of bed use by different GP practices can be seen across one city, after controls are applied to the data to account for factors of age, gender and deprivation
- Prompts the question – what General Medical bed capacity should the hospital plan for? If all practices were operating at the same level as Practice 1, 70 beds would be needed. If all were at the average, 44 beds would be required. If all were operating like Practice 12, the requirement would be 28 beds. What are the reasons underlying the variation in practice and outcomes?
- More generally, we estimate that approximately 45% of Health Board spend is determined by the decisions made by GPs, for which they are not directly financially accountable. This type of analysis will, we hope, provide data around which discussions can be focussed on current practice and its consequences.

Figure 4: Risk of death in hospital – across one Health Board, 2007-08



Points to note:

- This example provides a particularly direct illustration of the link between investment decisions and outcomes for people.
- We know that most people would rather die at home if possible than in an institution.
- In this Health Board, the risk of dying in hospital was measured across 13 localities (each locality is a geographical grouping of GP practices).
- Patients in locality 13 who died in this year had a 37% chance of dying in hospital. In locality 1 the risk was 70%.
- The question is – what accounts for the variation? And what should decision makers be considering with respect to current practice and investment decisions to ensure best use of resources and outcomes for people?

Annex B: The IRF and the Triple Aim of a rational care organisation

The principles underpinning the IRF are based on the 'Triple Aim' of a rational care organisation, which the Institute for Health Improvement (IHI) defines as:

- Improving population health;
- Improving individual experience;
- Reducing costs.

To achieve the Triple Aim requires:

- A clearly defined population (this may be geographical or care group);
- An understanding of the total resources spent on the care of the population;
- A care "integrator" that is empowered to direct resources to achieve the Triple Aim.

The first two of these preconditions are met by the mapping of health and social care resources in Phase 1 of the IRF; establishing the third is the focus of the work in the 4 test sites in Phase 2.

Empowering the integrator will require the test sites to develop financial arrangements to bridge the two disconnects within the local health and social care economy, i.e. within the NHS (between GP practices and CHPs; and between CHPs and acute hospitals), and between NHS boards and local authorities. These new financial arrangements will need to be incorporated into each partner's respective financial governance frameworks. The IRF team has commissioned research into financial mechanisms used in other health and social care systems and some of these have been suggested to test sites. However, the final decision on which mechanisms to use will be a local one.