IMPLEMENTATION OF THE INTEGRATED RESOURCE FRAMEWORK (IRF)

Report by Simon Steer, Head of Community Care Integration on behalf of Roger Gibbins, Chief Executive

The Board is asked to:

- **Note** the update on progress of the Integrated Resource Framework (IRF) in Highland.
- **Endorse** the proposal to implement the IRF at strategic, district/locality and small exemplas of change levels in respect of older people; and to explore lead commission in respect of Mental Health and Occupational Therapy Services.

1. Background

1.1 The Integrated Resource Framework (IRF) has been the subject of a number of reports to the Board. This proposal has evolved alongside national policy from one focussed on collaborative contracting within the NHS to an integrated approach with local authority partners.

1.2 The Partnership of Highland Council, Argyll & Bute Council and NHS Highland has been identified by the Scottish Government as one of four of test sites. The purpose of these is to develop data, methodologies and protocols required for:-

- a resource framework built around the costs of health and social care activities which would empower commissioners of services to direct resources to appropriate services;
- a joint strategic commissioning and capacity plan that set down the large volume costs and balance of services required over the next 10 – 15 years, together with an implementation programme; and
- a partnership financial framework that would enable the partnership to identify the combined resources and support financial governance arrangements that would reinforce partnership working.

1.3 In short, the aim of the Integrated Resource Framework is to describe how we currently use our collective resources, ask if there is a better way and then find a method to reassign resources to support the redesign services to achieve better outcomes and improve patient care.

2. Decision Making Arrangements

2.1 The understanding of resource use and the ability to move resource around, and across the system, is seen as an important enhancement to emerging new decision making arrangements.

2.2 In the case of both Argyll and Bute, and North Highland Partnerships, there is a recognition that there requires to be an incremental devolution of decision making towards the lead professional, and if possible to the service users, through supported self assessment and direct access to some services. In addition, many of these processes need to become more integrated across the Council and NHS Highland, be that at practitioner or manager level.

2.3 A necessary first step in this process is to devolve significantly greater decision making to local managers, bringing together Health and Social Care Teams in local geographies. In North Highland, where there are some issues of non coterminosity, the phrase "District" has been adopted to describe this local level. In Argyll and Bute, this level is already well established as a "Locality" structure.

2.4 It is expected that this approach will enable both enhancements and efficiencies in the management of services and will create local collaborative relationships within a shared boundary, to achieve:

- Single point of entry for health and social care service
- Self-sufficient for non-specialist provision
- Collaborative partnerships
- Some co-location
- Local, joined up and devolved decision-making

2.5 In the Highland Council area there will be nine of these Districts:

- Caithness
- Sutherland
- Easter Ross
- Skye & Lochalsh
- Lochaber
- Mid & West Ross
- Nairn, Badenoch & Strathspey
- Inverness East
- Inverness West

2.6 In Argyll and Bute there are four established Localities:

- Helensburgh & Lomond
- Cowal & Bute
- Mid Argyll; Kintyre; Islay & Jura
- Oban; Lorne & the Isles

3. Mapping of Current Resource Allocation

3.1 "Mapping" (the exercise to define where resources are spent, how and on whom) has been progressed by NHS Highland with Highland Council and Argyll & Bute Council. This exercise indicates that there is variation in the use of resources across the Highlands which cannot be explained as a function of population characteristics such as age structure, deprivation or rurality.

This work forms the underpinning understanding to answer the question "How do you use our resources?" before moving to consider the next questions of "Is that the best way?", and "Is there a better way?"

3.2 This leads to two further key questions:

The first is the question of *equity*. Having allowed for different population characteristics, are some areas receiving more per capita resource than others even though we have allowed for issues such as rurality?

The second issue relates to *efficiency* of resource allocation, and asks whether the use of more resource per head leads to better outcomes?

3.3 More work is required to refine the mapping exercise, however, mapping of activity and cost, whilst compelling and interesting, could also be endless. We are therefore adopting a pragmatic approach whereby we focus on the information that we wish to do something with, i.e. those areas of variation in practice or population where we believe that a change for the better could, and should, take place.

4. Identifying populations of interest and implementing the Integrated Resource Framework

4.1 The mapping work has confirmed that there are major challenges regarding resource allocation across all client groups across both Highland and Argyll & Bute Partnerships. Clearly though, the greatest challenge involves older people, specifically because of:

- The very high proportion of resource dedicated to unscheduled care and institutional settings
- Expected demographic changes, involving growing numbers of older people
- The pressing need to shift the balance of care

4.2 Older People

The Integrated Resource Framework Project Board therefore recommends that we now take forward the framework in three particular ways with regard to older people.

- The Strategic NHS/Council population level, where the use of the total resource applying to a population, (in this case the per capita resource available to the over 75year old population of the NHS/Council area) will be the focus.

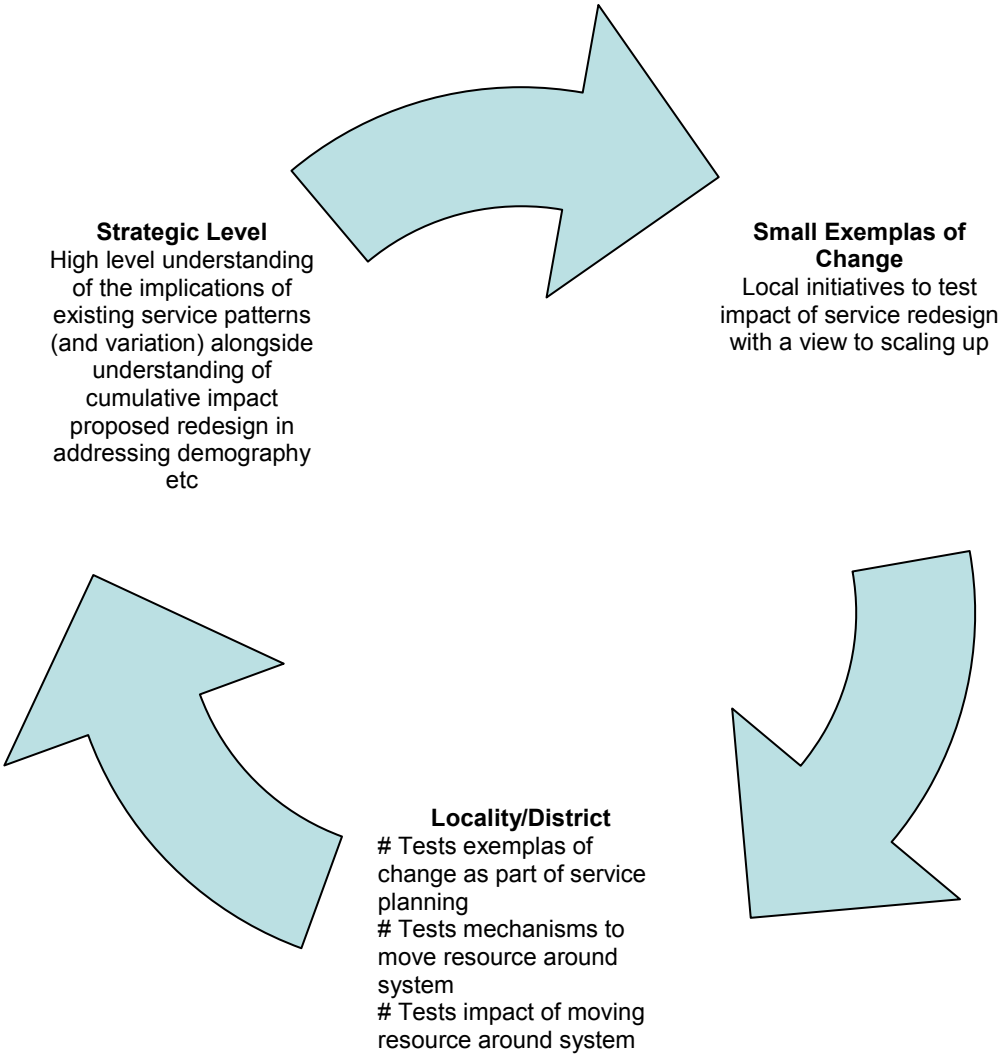
  One key area of interest lies in the activity and costs around unplanned emergency admissions to hospital, leading in turn to a high use of residential care. Achieving this will require further refinement of the available information (mapping) and interrogation of the variation in activity (that cannot be simply explained by demography) that we already know exists.

- Small, local exemplas of change, such as the innovative “virtual wards” in Nairn and Invergordon, will be supported across the Highlands and, where evidenced as positive, grown on.

- At a Locality or District level, to allow a joint per capita financial envelope to be used for the >75yr population to be used with flexibility across the normal NHS/Council budget divides.

  This represents a major initiative and challenge to free the chosen area from existing structural constraints to operate a “whole system” approach to planning and investment, where resource is allowed to move unfettered between and within organisations.

  The diagram below shows the interrelationship between each of these levels in developing innovation; practice and learning across the IRF programme.



In respect of level 3, work has been undertaken to identify the Locality or Districts that can best demonstrate where this approach can be implemented.

In Argyll and Bute the decision has been taken to focus on Cowal and Bute as the geographical area of interest.

In North Highland, proposals are currently being developed through the Joint Community Care Management Team, for consideration through the IRF project structure. As a Framework, the Project Board has agreed there should be two pilot district initiatives, one within the 70% Group area and one outwith.

This activity will require the development of governance and financial protocols at both the Locality/District and strategic levels to ensure that whilst the resource is able to be used flexibly, we are still able to account as required at present. This work will give an indication of the types of protocols that may be required in the future.

4.3 Lead Commissioning

Further, the Project Board also recommends that the IRF is taken forward on a pan-Highland basis across identified areas of service delivery. Using the provisions of the 2002 Community Care and Health (Scotland) Act, this means that the partners would:

- Agree the outcomes that they are looking to achieve
- Benchmark and define the partners contributions to the resource pool available to achieve these outcomes

- Decide which partner will deliver these objectives
- Frame the legal agreement and move resource
- Redesign services as required
- Review progress against agreed outcomes

Rather than achieve the better use of resources as part of total system change within one local geography, this uses a "lead commissioner" model, to achieve better deployment within one agency on behalf of the partnership, across a whole service area.

The Project Board has initiated work to examine the opportunities presented to take this approach forward in the spheres of:

Occupational Therapy Services

1. In Argyll and Bute, a single Occupational Therapy Service has already been developed, and the focus of work here will be to:
   - Consider any enhancements possible through the IRF programme.
   - Examine any possible pan Highland opportunities
   - Share Learning

2. In the case of North Highland, the initial scope of action is to explore the possibilities for a single NHS/Council service.

Mental Health Services

1. In North Highland there is an ambition to explore the possible opportunities for a single Mental Health Service. This will require consideration of not only the points in 4.5 above, but also a detailed examination of the statutory implications (already initiated with the support of the Scottish Government)

2. In Argyll and Bute, there is an enthusiasm to be engaged in the development of this model with a view to considering applicability to that area.

Just as the locality/District model will require the development of specific protocols, work will have to be scoped to ensure that the lead commissioning model in these services is achievable in terms of both service delivery and sound with regard to governance and financial management.

4.4 **Timescale**

It is envisaged that the necessary further developmental and scoping activity for all this work should take place between now and early 2011, to enable this to be reported to the Council and NHS Highland, and (if agreed) for the changes to commence in April 2011.

5 NHS Specific Actions

NHS Highland has previously indicated a plan to support a "collaborative contracting", or commissioning, approach towards planning and investment, within the NHS.

The essence of this approach is that:

- The CHPs develop "capacity plans" which state the balance of acute and specialist to community activity
- These plans are costed and a view established and agreed on the levels of resource that can be released to follow patients to where their care is planned.

- Reviews take place to examine actual activity (and associated cost) against planned activity to make adjustments as required.
- Budgets are restated to reflect activity.

All CHPs have had the opportunity to reflect upon a previous iteration of cost and activity information with a view to developing costed capacity plans. This information is currently being updated to reflect 2010/11 costs.

Following from this report, a series of visits to CHPs have been arranged to:

- Discuss development of capacity plans to date
- Agree any further support or information required to support these developments
- Agree timeframes for capacity plan development
- Support development of the Capacity Plans

It is recognised that the progressing of this work will require development of commissioning competencies, and further clinical engagement. To this end, the NHS Highland IRF Steering Group will be developed as a setting in which to develop a local commissioning competencies programme.

6. Contribution to Board Objectives

The development of the IRF contributes to achievement of a *"Better Health, Better Care, Better Value"* recommendation.

7. Governance Implications

The principle **governance** impact lies in the requirement to develop new protocols and arrangements to allow resource to move across the whole system.

Finance impacts lie the implications of moving resource around the system.

Highland Council and Argyll & Bute Council will be seeking similar endorsement for this work within their own governance arrangements as appropriate.

8. Risk Assessment

The principle risk lies in the national expectations of this initiative as part of a national program. This paper reports that Highland progress is on track.

9. Impact Assessment

Update report, no update at present to impact status.

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