Integration across Health and Social Care Services in Scotland – Progress, Evidence and Options

1. Purpose

1.1 This note reflects upon the proposals on integration across health and social care services contained within Sir John Arbuthnott’s recent Clyde Valley Review. It draws upon experience from the last 10 years’ commitment to improve joint working in Scotland and highlights some of the current work within the Scottish Government and across partnerships relating to integration, particularly the introduction of an Integrated Resource Framework (IRF) for health and social care.

1.2 The Annex material provides a summary of some of the available evidence on integration, additional background detail and references.

1.3 Please note that this paper makes use of the word commissioning to describe the planning and investment activity associated with provision of care services.

2. Context – recent and current work on integration

2.1 Effective partnership working between the NHS and local authorities is widely recognised as a prerequisite for achieving good health and social care outcomes. For the last decade in Scotland the focus has been on achieving better outcomes through partnership working, service redesign and the development of integrated clinical and care pathways (see the Community Care and Health (Scotland) Act 2002; the Partnership for Care (2003) White Paper; Better Together; establishment of CHPs via the NHS Reform (Scotland) Act 2004).

2.2 In the early years of joint working between community health and social care services, and particularly under the auspices of Joint Future, there was a strong focus on improving processes, on the assumption that good partnership working arrangements would lead to good outcomes. Joint structures, HR arrangements, financial frameworks and assessment procedures were all seen as critical to enabling good joint working across statutory organisations.

2.3 However, it was also recognised that changes to systems, processes and structures alone cannot deliver improvements – the quality of leadership, vision, communication and behaviours in Partnerships are also all critical factors.

2.4 The development of CHPs in 2004 was intended to build on the success of partnership working up to that point, and included a strong focus on organisational
development to support new ways of working across health and social care. A national study examining the outcomes of introducing CHPs is underway and will be published in April 2010; provisional results indicate that, in terms of partnership working, substantial progress has been made, but there is still a good deal of scope for improvement.

2.5 In an attempt to strengthen involvement in decision-making by local authority partners, a few areas have evolved their CHP committee structures to reflect greater involvement of elected members, e.g. Edinburgh City CHP, West Lothian CHP and Glasgow City CHCP. Scottish Ministers have also recently approved revised arrangements for Borders, Ayrshire and Orkney.

2.6 NHS Scotland is explicitly an integrated healthcare system, with integration across commissioning and provision. Within social care, the focus is principally on local authorities commissioning services from a range of providers – and some services may be provided in-house. In terms of governance, structure and culture, councils and the NHS are therefore operating within inherently dissimilar environments, with implications for any move towards greater integration. Even within health, no one culture or set of governance arrangements operates; integration by itself will not overcome the difficulties that that can bring.

2.7 Work is underway to develop and test an Integrated Resource Framework (IRF) for health and social care services in Scotland, with four test site Partnerships – Highland, Lothian, Ayrshire and Arran, and Tayside. The IRF responds to the observation made by many of those working in health and social care that they could deliver better outcomes for people if resources could be moved around the health and social care system more effectively to support shifts in the balance of care.

3. What is integration?

3.1 Integration can take place at different levels, at different levels of complexity, and for different purposes. Though many countries have introduced a range of mechanisms to integrate care in recent years, the lack of common terminology to describe integration makes it complicated both to reference the literature\(^1\), and to arrive at a straightforward and commonly understood definition. For the purposes of this note, we have adopted Kodner’s definition\(^2\):

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\text{Integration is a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration … to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long term problems cutting across multiple services, providers and settings.}
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3.2 The World Health Organisation (WHO) defines integration as the “bringing together of inputs, delivery, management and organisation of services as a means to improve services in relation to access, quality, user satisfaction and efficiency”\(^1\). The WHO, with others\(^2\), has developed a helpful framework for considering integration, based on a continuum, which is clear that integration can be achieved by means other than structures and systems. Further details are provided in Annex A. Progress in Scotland towards integration is described in section 5.
3.3 Key lessons from the available evidence on effective integration, summarised at Annex B, are:

a) *Integrate for the right reasons*; successful integrated systems have grown organically with strong clinical and professional leadership; attempts to impose integrated care in a top-down manner have been less successful. The objectives of integration need to be made explicit to all those involved in the planning and delivery of care.

b) *Don’t necessarily start by integrating organisations*; integration that focuses mainly on bringing organisations together is unlikely to create improvements in care for patients; an alternative approach is to begin integration at the frontline, which does impact directly on the patient experience.

c) *Ensure local contexts are supportive of integration*; these include a culture of quality improvement; existing multidisciplinary teams; local leaders who are supportive of integration; personnel who are open to collaboration and innovation; and effective and complementary communications and IT systems.

d) *Be aware of local cultural differences*; the evidence reports the very significant challenge of bringing together organisational cultures that have, in many cases, evolved separately over decades.

e) *Ensure that community services don’t miss out*; integration per se won’t address the power imbalances between acute and community services and financial levers must be designed to overcome this.

f) *Give the right incentives*; it is important that clinical and care professionals recognise the benefits and lead the integration process as a means to an end and not an end in itself. This may require not just persuasion from a clinical standpoint, but in the form of budgetary incentives.

g) *Don’t assume economies of scope and scale*; significant improvements in quality of care are likely to follow well designed and implemented integration of previously fragmented service providers. Potential economies of scope and scale are likely to take time to achieve.

h) *Be patient*; the time required to implement effective integration is a recurrent theme and is unsurprising given the scale of the changes required to realize the potential benefits.

i) *Leutz’s sixth law*; all integration is local and success will hinge on strong local leadership identifying solutions to specific local problems.
4 Why integrate?

4.1 The basic argument for taking an integrated approach to planning and service delivery is that service users should be able to access effective, efficient and well co-ordinated care services from a range of providers. By overcoming fragmentation and minimising organisational barriers between providers of care, it should be possible to improve outcomes for service users, and the experience of using services, as well as reducing duplication.

4.2 A further argument for integration lies in the inter-dependence of service providers’ respective and shared objectives. An obvious example of this is the shared responsibility of health and social care for tackling delayed discharge; health improvement, with responsibilities across health, social care, environmental health and housing provides a further example.

4.3 This inter-dependency can result in the costs generated by decisions and actions undertaken by one Partner adversely impacting on another Partner. The consequence of these costs, if not jointly planned for and agreed, is sub-optimal resource use. One of the key benefits of having an integrated approach is that these costs are internalised to the whole system, encouraging a principle of resource “stewardship” across the Partnership and promoting more effective resource allocation and use.

4.4 The purpose of the IRF is to enable Partners to follow the totality of resource available to them as they plan services and make investments across and within organisational boundaries, and then to measure outcomes against that investment of time and money. The aspiration within the test sites is to create an environment that empowers local Partners to develop and implement forms of integration that are best suited to local circumstances – which may be any or all of the non-structural forms of integration listed above.

4.5 The benefit derived from integrating the entire resource invested in the care of a population, in terms of improvements in quality, equity and efficiency, has been argued by the Institute for Health Improvement (IHI) in its development of the concept of a “Triple Aim”. Briefly, this demonstrates that a rational care organisation would have three inter-related aims - to improve population health; to improve individual experience of care; and to control costs - and that three pre-conditions must exist if these are to be achieved:

1) A clearly defined population of interest, which may be geographical or a care group (e.g., children, older people, mental health, learning disabilities etc).
2) Understanding of per capita costs or care for the defined population; this should be for all care for that population.
3) An established integrator, which has overall responsibility for determining how best to achieve the goals of the ‘Triple Aim’ for the defined population.

4.6 The key success factor is the establishment of the integrator, whose role is to co-ordinate and direct the resources allocated to a population group to improve outcomes for that population. The integrator function may be lodged within a structure that already exists – such as the CHP or local authority. Identifying the integrator and developing methods for financial integration are the focus of the IRF
test sites, and the principles of the IRF are rooted in the philosophy of the Triple Aim. Further details on the function of the integrator are provided in Annex C.

5 Integration in Scotland – progress to date

5.1 Ham’s\textsuperscript{14} description of a range of integrated arrangements can be applied to health and social care in Scotland, with progress summarised as follows:

5.2 Integration of GPs and other healthcare professionals working in the community in the extended Primary Care team

Although the organisation of NHS Scotland is predicated on an integrated system, the reality is that, for the most part, GMS practices are private partnerships that are commissioned by NHS Boards to provide services. Strengthening the links between GPs and extended Primary Care teams will support the development of new models of care in the community and help to maximise the skills of non-medical practitioners.

5.3 Integration of the extended primary care team with social care professionals

Integration between NHS Scotland and social care was led from the outset by the Joint Future initiative, which placed strong emphasis on improving processes in the belief this would lead to improved outcomes. As described above, process has proven to be a necessary, but not sufficient, for successful delivery of better outcomes.

5.4 Integration of the extended primary care team, social care professionals and hospital based specialists

The degree of integration between CHPs and specialist services is not as strong as it could be. In most Boards there is no budgetary link between CHPs and their use of hospital capacity. It is estimated that GPs in Scotland currently commit approximately 45% of total NHS Board expenditure by their clinical decisions, for which they are financially not accountable. The focus of integration has tended to be through Clinical Networks and NHS Scotland wide collaboratives (e.g. the unscheduled care collaborative). However, these overlay the formal organisational and resource management structures within Boards, which can lead to tension with “real” budget holders over accountability.

5.5 In Scotland, Partnerships currently sit at different points along the WHO’s continuum of integration, and include some or all of the following:

- Joint committees
- Joint financial reports
- Joint planning forums
- Some shared performance management tools and reports to statutory bodies
- A predominance of aligned budgets for community and social care, which tend to exclude budgets for unplanned hospitalisation
- Some joint appointments, including Joint Directors of Community Care. In most cases, Joint Directors manage joint funds as separate budgets for each Partner, in accordance with their individual financial governance arrangements
Some pooled budgets, which tend to be for relatively small standalone projects such as community equipment stores. There are a few notable exceptions, for example the pooled budget for mental health services in Clackmannanshire.

Co-location
Sharing of some HEAT and SOA targets and standards
Clinical and care networks that focus on pathway development.

5.6 The recent Clyde Valley Review by Sir John Arbuthnott proposes a significant shift along the continuum towards full integration of at least some services, including community healthcare and social care, for the eight councils and their respective Health Boards within the Clyde Valley Community Planning Partnership, but is silent on how this should be achieved. The focus of the Arbuthnott review is efficiency savings, rather than the potential wider benefits pertaining particularly to patient and service user experience.

5.7 Arbuthnott identified three main types of barrier to integration, which apply not only to the Clyde Valley, but across Scotland, as follows:

1. Geography – although smaller subgroups of authorities (than the eight referred to in the Review) could develop a shared operation where geographical challenges prevented integration right across the Partnership.

2. Clarity on delegation under current legislation – the Review notes that current legislation is clear on how local authorities can delegate statutory duties to other authorities, but delegation to other bodies (such as an arms-length arrangement) is less clear. Different views on application of the Power of Wellbeing prevail, which may present a barrier.

3. Equal pay – if services are provided by another body then TUPE is likely to apply, and staff would transfer to the body which is the new provider. This may present a barrier because not all local authorities have yet tackled equal pay issues; they may have used different comparators; and they are likely to use different salary scales. The Review also notes that this is potentially a major hurdle when sharing with other local authority partners, such as Health, which have different pay and conditions structures and substantially different comparators.

5.8 Closer integration towards a single health and social care service was also strongly recommended in the Wanless reports, within Scotland, it is worth noting that current legislation already permits elected members to take a greater role in strategic decision making within the NHS.
6. Potential for further integration in Scotland

6.1 The current legislation governing health and social care partnership working (Community Care and Health (Scotland) Act 2002) makes it a duty to work in partnership but all the practical measures to facilitate this are powers – most notably the power to transfer specific functions, without removing statutory responsibilities, and the associated powers to transfer budgets to create pooled budgets.

6.2 The benefits of integration can be realised in Scotland using the flexibilities already permitted by existing legislation, assuming strong local professional and political leadership and commitment. Current legislation also gives Ministers the power to direct local authorities and NHS bodies to enter into joint working arrangements where Ministers consider this would improve the bodies’ performance of their functions. These powers have not been used to date and are seen as a last resort, given that their implementation would in itself carry a high degree of risk.

6.3 A number of options are available which could be used to yield the benefits of increased integration without legislative change; evidence about their effectiveness will be available from the IRF test sites, which should inform future decisions:

- Increased use of comprehensive budget pooling – marginal pooling of small, “safe” budgets will not deliver the economies or flexibilities that demographic and fiscal pressures demand.
- Introduction of lead commissioner and provider arrangements, similar to those seen in English Care Trusts, such as Torbay and North East Lincolnshire. In the Scottish context, this could be achieved with a CHP acting as the integrator. Further details on lead commissioner arrangements are provided in Annex D; background information on aligned and pooled budgets can be found in Annex E.
- Development of a nationally-led OD programme, to improve commissioning capabilities within Partners.
- Greater emphasis, locally and nationally, on development work focused on shared vision, goals, decision making, resource utilisation, delivery of agreed targets and outcomes, with aligned incentives for involvement in clinical/care pathway redesign and delivery.
- Extended application of the IRF, taking into account evidence that will be forthcoming from the test sites.

6.4 Integration of patient-level commissioning of services is an increasingly important issue, particularly for local authorities, which should also to be taken into consideration. Patient-level commissioning implies fragmentation of commissioning; Kodner\textsuperscript{21} reports, however, from studies undertaken in Austria, Germany, the Netherlands and the US that it can encourage more flexible service use and greater consumer satisfaction and quality – without harming inherent efficiency and effectiveness.

6.5 Understanding patient-level activity and cost is critical to the developing Self Directed Support agenda. Without this information for health and social care, allocation of funding to individuals, and consequential planning for investment and disinvestment, can be little more than guesswork.
6.6 The role of the third sector in terms of service provision also needs to be thoroughly explored, especially in the context of new types of provider organisations such as co-operatives, community businesses and co-production models.

6.7 Given that there is headroom within the flexibilities enabled by current legislation for greater integration, it is important to consider what the obstacles and inhibitors to integration may be. The evidence base for integration in developed economies identifies many common and overlapping barriers to integrated care, including:

- Strong institutional and sectoral responsibilities expressed through vertical and organisationally discrete power structures;
- Funding streams, budgets and accountabilities remaining separate; and
- Cultural, educational, professional and language differences and difficulties.

6.8 Lack of progress in Scotland, despite an enabling legislative environment, is attributable to the focus on structures and processes described earlier; lack of incentives in recent years in an environment of increasing budgets, with no real urgency to focus on the totality of resource use rather than marginal adjustments; lack of concerted leadership; Local Authority wariness of Acute dominance within NHS Boards; different governance arrangements (Single Outcome Agreements and HEAT); and cultural differences, particularly in relation to separation of commissioning and provision.

6.9 In England, a recent review by the Audit Commission\textsuperscript{22} of the use of available flexibilities there found barriers to integration as follows:

**Cultural**
- Differences in the approach to commissioning services was seen to be a barrier, with Local Authorities focusing on individuals and the NHS focusing more on pathways.

**Organisational**
- Different terms and conditions, pensions and contracts seen as an impediment to staff transfer;
- Difficulties in alignment and synchronisation of data systems to inform planning and performance management;
- Alignment of corporate objectives at local level is essential, but has been made difficult by the different accountability arrangements of partners.

**Financial**
- Partners not aware of the full flexibilities available, and all flexibilities often referred to as pooled funds, regardless of their true nature;
- Governance arrangements for financial mechanisms can be complex and act as a disincentive to pooling resources and risks;
- Different financial regimes perceived as a barrier to further use of joint financing mechanisms - differences in VAT regimes; charging; financial planning and budget-setting timetables; financial reporting arrangements; and accountability and governance arrangements.
6.10 Central government policy is also identified by the Audit Commission as a barrier, with the focus tending to be on process and structures rather than outcomes, and particularly a lack of consistency in policy development between Departments. An example of this is found in the NHS development of its World Class Commissioning programme, which has focused on NHS planning alone to the exclusion of integrated commissioning of Health and Social Care.

6.11 Where success is seen, leadership is consistently identified throughout the range of evidence as a key factor, as reflected in the lessons learned noted at para 3.3.

6.12 In Scotland, the Arbuthnott Review can help progress by encouraging discussion informed by “neutral” recommendations. Although the Review describes “what” is desirable in terms of integration, it leaves the “how” up to local and central government. An important aspect of the work on the IRF is that it provides part of the answer to the question of “how” in terms of financial integration, by introducing mechanisms for valuing activity and transferring resource between Partners.

6.13 Current financial constraints, the challenges associated with demographic change, and the possible introduction of different structural arrangements in England after the UK election, may lead Scottish Ministers to provide much stronger direction to Health Boards and Local Authorities regarding the need to plan, invest for, and deliver services that are better integrated. Whether or not Scotland pursues structural integration across health and social care, there is scope in the short to medium term to provide clear central direction regarding the imperative for change and improvement.

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Annex A – Models of integration

The WHO considers integration in the context of three dimensions: type, range and domains of integration.

a) Type of integration

By type of integration, the WHO is referring to the degree of formality of integration between organisations. A continuum of partnership is described that passes from autonomy of individual organisations at one extreme, through linkage and co-ordination to full integration at the other extreme.

Characteristics seen across the continuum are typically:

Full segregation
- Autonomous organisations
- Self-determined independent corporate objectives
- Separate funding streams
- Operating frameworks, which may not fully reflect inter-dependency with partners

Linkage
- Autonomous organisations
- Separate funding streams
- Aligned operating frameworks that recognise inter-dependency through coherent systems and policies e.g. shared guidelines
- Sometimes referred to as systemic integration

Co-ordination in networks
- Complementary corporate objectives
- Existing systems and structures remain largely intact
- Alignment of planning and/or provision of services through purpose-built structures e.g. Chains of Care and Managed Care Networks
- Sometimes referred to as normative integration

Full integration
- Single set of corporate objectives focused on the needs of the service user
- Single system of financial, risk and performance management
- Full integration may be structural (via formal merger) or virtual (via contracting mechanisms)

b) Range of integration

The range of integration is a measure of the complexity of the care system being integrated, in terms of the number of different organisations and sectors involved.
c) **Domains of integration**

This refers to the range of organisational functions being integrated, such as finance, support services, management and clinical/care service delivery. Details on the main characteristics of models of financial integration are provided at Annex A.

This framework provides a mechanism for describing, and differentiating between, the full range of integration scenarios.

The most appropriate combination of degree, domain and range of integration will depend on the characteristics of the patient population and the specific challenges they face in obtaining appropriate, quality care. Generally, patients with particularly severe and unstable conditions requiring intensive, ongoing medical and social attention from a host of providers for relatively long duration would require a complex solution necessitating increasing degrees of integration from several of the operational domains described above; less complex patient groups would require a narrower span and less thoroughgoing interventions.

Integration along the three dimensions within the framework may be either:

- **Horizontal**: integration across organisations at respective stages of the care pathway (e.g. extended primary care teams) or
- **Vertical**: integration within an organisation of key stages of care along a care pathway (e.g. primary with secondary and tertiary care).

Both horizontal and vertical integration can be applied to the provision or the commissioning of care, but in practice there are important differences in their application.

Vertical integration can be applied to the provision of services (for example integration of extended primary care teams with acute elderly medical services in a frail elderly network) and also to commissioning and provision of care.

Any progression along the spectrum to full integration would require Partners to supplement their respective corporate and financial governance arrangements to allow proper accountability for partnership activity.
Annex B – Evidence for integration

Until relatively recently there has been a sense, most frequently articulated in research from the UK, that more is known about the impact of integration on partnership processes than its impact in terms of outcomes for people. There is now, however, a growing range of evidence from which to draw for empirical support for the theoretical benefits of integration. Our own evaluation of the IRF test sites will add to this evidence base.

It is important to bear in mind that evidence from specific settings is local – i.e. the best integrated care is designed to find specific solutions to local problems. Furthermore, success depends, in large part, on local leadership and partnership working, rather than top-down structural solutions and directives.

In broad terms, the evidence suggests that integration can be an effective way of delivering care and that it can provide opportunities to break down barriers between primary and secondary healthcare, as well as between health and social care.

Although there is some evidence to show that virtual integration using networks can provide a valid alternative form of care delivery to the more formal reorganisation involved in horizontal or vertical integration, in broad terms, the benefits of integration tend to be proportionate to the degree and extent of integration.

Limited models of integration demonstrate improved co-operation between partners, a greater readiness to engage users and carers, improved service packages, synergy and added value.

Evidence from models of deeper integration in the USA, Canada, Sweden, Italy, England and the Netherlands suggests that integrated models impact favourably on outputs such as rates of hospitalisation (admissions, re-admissions, length of stay) and on costs. The cost effectiveness of the intervention depends largely on the system of care within which it is introduced.

Evidence for the impact on outcomes from these models is less strong, but suggests a promising pattern of improved access, functional decline, quality of life, carer burden and client satisfaction. The weakness of the evidence for impact on outcomes may reflect the fact that it takes time to effect demonstrable changes in organisational structures and processes and for resulting new services to become stable systems of care that affect outcomes.

In general terms, the common pre-requisite for successful integration of health and social care is provision of a suitable context in which the integration can take place, i.e., supportive and strong leadership, strong local partnership arrangements and effective IT and administration systems. More specifically, the following design features are commonly considered to be key contributors to success:

- Focus for purpose of planning and delivery on a defined population for care (e.g., older people, children etc., or the population of a defined geographical area);
- Umbrella organisational structures in place to guide integration on strategic, managerial and service delivery issues; to encourage and support effective joint working; to ensure efficiency; and to maintain overall accountability for service,
• Arrangements for case management, geriatric assessment, multidisciplinary teams and co-ordinated care packages in place;
• Single entry point for service users;
• Organised provider networks with standardised referral procedures, service agreements, joint training and shared information systems;
• Financial levers to promote prevention, rehabilitation and downward substitution of care (e.g. capitated budgets for the entire care for the target population).
Annex C – Function of the integrator

What is an integrator?

The ‘integrator’ is a term coined by the Institute for Health Improvement (IHI) in relation to its concept of a “Triple Aim” as described below. To achieve the most appropriate allocation of resource for a specified population, some form of agreement between organisations must be in place to move resource between two points in the system. The integrator is the term used to describe a locally recognized entity that decides where resource should be directed to improve outcomes for the given population. Currently in Scotland there exist no formal governance structures to oversee the fair and efficient allocation of resources between providers.

What does the integrator look like?

The integrator is not an individual, but rather an organisation or partnership of organisations (such as a CHP) that is able to induce coordinative behaviour among the providers of care to work as a single system for the population and with a clear formal role in overseeing resource allocation, and one which is recognised by all partners. Test sites have been given a degree of flexibility in deciding upon the specific character of the integrator role, which will depend to a large extent upon existing local governance structures.

Why do we need an integrator?

The IHI’s concept of a “Triple Aim” argues that a rational care organisation would have three inter-related aims:

1) To improve population health;
2) To improve individual experience of care;
3) To control costs.

The pre-conditions for achieving the Triple Aim for a given population are:

- A clearly defined population of interest; this may be geographical or care group.
- Understanding of the per capita costs or care for the defined population; this should be for all care. Although the IHI focused on healthcare, in Scotland we’ve extended this to include social care.
- Establish an Integrator; the integrator has overall responsibility for determining how best to achieve the goals of the ‘Triple Aim’ for the defined population.

The integrator’s role is to co-ordinate and direct the resources allocated to a population group to improve outcomes for that population. For example, the integrator may elect to transfer a portion of a hospital budget to home care teams or voluntary organisations to facilitate interventions that reduce unplanned hospital admissions among the frail elderly and also reduce delayed discharges from hospital.
This will typically involve changes to current investment profiles, in other words disinvesting in one organisation to fund investment in another, and will require agreed mechanisms to allow this flow of resources to take place. In addition to identifying the integrator function for their populations of interest, test sites have been asked to outline mechanisms to allow the integrator to make optimal investment decisions.
Annex D – Lead Commissioner models – Torbay and North East Lincolnshire Care Trusts

Lessons can be learned from experience elsewhere, including England, notwithstanding the contextual differences in terms of demography, legislation and organisational structures. Although there are some differences, the enabling legislation in England allows the same degree of integration across health and social care as is permitted by legislation in Scotland. Experience in England has until recently been similar to that in Scotland, with the same constraints acting to inhibit progress along the continuum.

In recent years, however, a small number of English Partnerships have been developed that have used the flexibilities in the legislation to achieve significantly greater degrees of integration than previously seen. The examples are provided by way of illustration; to understand their implications more fully we would need to set them more fully against the English NHS context.

The organisational form of the Partnerships varies in detail, but the general principle is that Partners retain responsibility for their respective statutory duties, but achieve these by delegating responsibility and resources through contracting mechanisms. These agreements are time limited contracts, usually in the form of rolling three year contracts with the following provisions:

- Delegations;
- A Strategic Agreement setting out the strategic direction of the partnership underpinned by a more detailed 3 year plan, reviewed annually.
- A Performance Framework that allows delegating Partners to performance manage the delivery of the delegated responsibilities;
- Specifications for Value for Money reviews;
- Establishment of a pooled fund for revenue expenditure with respect to prescribed functions, including protocols for the treatment of over/underspends.

These arrangements enable full pooling of material resources. So, for example, a Local Authority (LA) may contract for the delivery of adult social care with the NHS, transferring both the adult social care budget staff to the NHS, with the Director of Social Work retaining accountability for the adult social work service and exercising control through the contract specification. The NHS body is generally re-classified by the Department of Health as Care Trust, rather than a Primary Care Trust, with formal representation by elected members on Care Trust Boards. The Board is empowered to target pooled resources to achieve the integrated corporate objectives.

In 2009 there were 10 Care Trusts, as described above, in England, and brief case studies of two examples are presented below. Officials are establishing contact with both of these Trusts, and others, to establish what can be learned from their experiences.
Torbay Care Trust

The Torbay Care Trust was established in October 2005 by Torbay PCT and the co-terminous Torbay Council. The Care Trust serves a population of 140,000 centred around the towns of Torquay, Paignton and Brixham. 23% of the population is over the age of 65, and the area includes some wards of high deprivation. The Care Trust is responsible for commissioning and provision of all adult health and social care services for the people of Torbay.

The following have been integrated by the Care Trust:

- Corporate governance (performance management, clinical/care governance, financial governance, risk management and staff governance);
- Commissioning of health and adult social care services, with a view to delegating this to localities and individuals;
- Provision of health and adult social care services, structured around 5 localities based on groupings of GP practices;
- Support services including finance, HR, payroll, estates, communications and consultation.

800 Council staff from the following areas have transferred to the Care Trust:

- All care management staff;
- All in-house provision;
  - Residential and intermediate care units
  - In-house domiciliary care
  - Emergency duty service
  - Learning disability services
  - Community alarms
- Support staff (finance/HR/performance);
- All adult social care commissioning staff;
- The financial assessment and benefits Team.

Within two years, the Care Trust was assessed as improving performance. Evidence is not yet available on performance in terms of impact on outcomes; officials are in the process of arranging to meet colleagues from Torbay and will ask about this then. So far, the Trust has achieved the following:

- Introduction of a single point of access to community care, with significant improvement in waiting times for assessment;
- Reduction in waiting time for packages of care;
- Named social workers for each GP practice, with social workers inputting to GP systems;
- Integrated occupational therapy service;
- District nurses commissioning packages of care;
- A long overdue review of in-house services;
- A review and closure plan for care homes;
- A review of home care including re-shaping of in-house home care provision and tender for external home care services;
- Development of specialist intermediate care support workers

Key lessons for successful partnership noted by the Trust are identified so far as:
• Clear and simple vision about what Partners are trying to achieve;
• Strong leadership from all partners at all levels.

North East Lincolnshire Care Trust

In NE Lincolnshire, the Partnership between the co-terminous Local Authority and PCT created a Care Trust in September 2007. The Partners serve a population of 157,000 living in Grimsby and surrounding rural hinterland, with significant levels of urban deprivation combined with material and increasing health inequalities.

The integration model in NE Lincs has three components:

• The establishment of a Care Trust to commission and provide Health adult health and social care services from a pooled budget. 677 staff (519 WTE) and £54.3m were transferred to the Care Trust, with the Director of Adult Social Services (DASS) function retained by the Council.
• An integrated Public Health and Wellbeing function managed by the LA with the transfer of the Public Health and Health Improvement team from the PCT to the LA, with 65 staff (56 WTE) and £2.03m budget transferred to the Council.
• A Children’s Trust hosted by the Council, with 117 staff (88.15 WTE) and £22.03m transferred from the PCT to the Council.

The following have been integrated:
• Corporate governance;
• Commissioning for health and adult social care through delegation to localities (average 40,000 population) centred on groups of GP practices, linking practice-based commissioning with the personalised approaches developed through direct payments and individualised budgets;
• Provision of health and adult social care, again delegated to localities structured around groups of GP practices;
• Public health and housing in one team, able to influence the wider determinants of health and well-being with an explicit remit to target health inequalities;
• Commissioning of children’s health and social care services;
• Provision of children’s health and social care services;
• Support services and back office functions.

As with Torbay, we do not have evidence on performance to report. Officials have visited Grimsby to learn from colleagues there, who reported that with creativity, strong local leadership and an emphatic focus on the needs of the local population, the flexibilities permitted by existing legislation are sufficient to achieve the potential for improved outcomes offered by integration. Although the organisational structures used in Scotland are different, Scottish legislation permits the same degree of integration between NHS Scotland and Local Authorities, most obviously through empowerment of CHPs as CHCPs.
Annex E – Aligned and Pooled Budgets

The flexibilities already introduced by legislation to enable financial integration are aligned budgets and pooled budgets. Further details on each are given below.

The main characteristics of *aligned budgets* are:

- Separate accountability: funding streams remain separately managed by each partner.
- Separate financial governance.
- Joint reporting of aligned resource: performance is monitored and jointly reported, but this tends to be little more than the reporting of each organisation’s figures side by side.
- Inertia in viring resource: a common example is the inability to use a vacant budget for a community nurse to fund home care assistants.
- No delegation of functions and no host partner: one Partner’s duties are not undertaken by the other.
- No need for formal agreements.

The main characteristics of *pooled budgets* are:

- A single fund: resources are transferred from one Partner to another.
- A host Partner: the fund is managed by a single Partner.
- Signed agreement: this sets out respective contributions, short and long term objectives, management arrangements and pool surplus/deficit sharing arrangements.
- Single financial governance: that of the host Partner applies to the pooled resource (with a single set of financial regulations).
- Unified operational reporting: typically with no differentiation between respective Partner’s resource.
- Freedom to vire resource within the pooled budgets.

*Lead Commissioner/Lead Provider* arrangements are a comprehensive form of pooled budgets in which the total resources for the care of a defined population are integrated in one organisation to either commission or provide the care for that population.

Lead Commissioner/Provider arrangements achieve the same degree of integration of resources as pooling, but it has the attraction of using existing transactional relationships between Partners, which makes the financial governance and performance management of the integrated resource more straightforward than is the case with standard pooling.

In terms of the WHO framework of integration noted above the IRF test sites will provide evidence of the effect of using aligned and pooled budgets for specific populations (care group or geographical, or both) to move to a point between the mid-point and full integration.
Annex F – Current legislation

This annex summarises the key legislative provisions taken into account in preparation for the introduction of the Integrated Resource Framework. Officials have not at this stage requested legal advice on the implications of structural integration across health and social care.

Community Care and Health (Scotland) Act 2002

Sections 13-17 refer to joint working arrangements between local authority and NHS bodies including:

- transfer of funds between each;
- transfer of staff; and
- Ministerial powers to require delegation between local authority and NHS bodies.

More details on joint working are included in the Community Care and Health (Joint Working etc) (Scotland) Regulations 2002. The functions for which partnerships can delegate responsibility are included in schedules 2 and 3 of the regulations and the exemptions are outlined in regulation 5(2) and (3). Any arrangement to delegate functions/pool budgets must be outlined in a written agreement (regulation 9 and the details to be included in the written agreement are included in regulation 11). The composition and management of a pooled fund, including audit arrangements, are included in regulation 10. There is also a requirement to consult on by arrangement (regulation 6). Guidance on the Joint Working regulations was issued in December 2002.

Local Government In Scotland Act 2003

This Act introduces three key considerations:

- The duty to promote Best Value;
- The duty to initiate, facilitate and maintain Community Planning; and
- The power to advance wellbeing

National Health Service Reform (Scotland) Act 2004

This legislation provides a setting in which the actions enabled by the Community Care and Health (Scotland) Act 2002 can take place.

Section 4A provides for the establishment of Community Health Partnerships (CHPs). CHPs are not independent statutory bodies, but are committees or sub-committees of an NHS Board. They operate within the Board’s policy, planning and performance management systems. Some CHPs have established Community Health and Social Care Partnerships that directly manage a range of community based health and social care services, and are responsible for services already delivered jointly under the Joint Future agenda e.g. community services for learning disabilities, mental health and addiction.

The statutory CHP guidance enables NHS Boards to devolve authority to CHPs to progress their Joint Future agenda locally. A CHP can pool budgets and enter into
joint management arrangements on a wide range of services. CHPs are developing joint approaches to governance arrangements for joint services with local authority partners including joint schemes of delegation, joint written protocols, and access to resources across agency boundaries and joint complaints procedures.

**Introduction of the IRF within the legislative framework**

Against this legislative backdrop, we have been mindful of the requirement to assure the following issues are properly addressed in the IRF test sites:

- Governance
- Delegation of functions
- Accountability for delivery of joint services
- Management structures
- Financial governance for aligned or pooled budgets for joint services
Annex G – References


12. Integrated Care Network: Advisory Notes 1-6, January 2006. www.icn.csip.org.uk


16. Sir John Arbuthnott: Clyde Valley review 2009


