Integration of Health and Social Care

NHS Tayside

Within Tayside the approach surrounded some key principles:

- Collaborative leadership – Project Team and Board Level
- Greater integration between health and social care
- Optimising the flow of resources
- Achieve the Triple aim – better health, improved experience at an economic cost

Each of the partnerships developed project plans tailored to meet the needs of the individual localities with these principles at the core and progress monitored through a project team and implementation board. Members of both groups were formed to ensure that all partners were appropriately represented together with the appropriate skills mix.

From the high level principles there were a number of objectives the individual project plans had to achieve which were:

- Using the outcome of joint performance information to inform potential changes to care pathways and enabling deeper review of variation data to shape change at local practitioner level.
- Clinician involvement in the planning and design of care pathways
- Identify links between changes to care pathways and outcomes
- Ensure equity across populations and allow more affluent areas to maintain health and resilience and allow the least affluent communities to build improved health and develop resilience.
- Define financial mechanisms to allow the flow of resources along the care pathway and across organisational boundaries.

In recognising both the cultural and organisational differences between the health and social care organisations the Tayside approach ensured that staff involved in the integration have been supported and a number of Organisational Programmes have been put in place.

**PROGRESS AND CHALLENGES**

**Data Mapping and Data Sharing** – In order to fully support the planning process it is essential to link health and social care performance information on both activity and spend to fully understand the patterns of consumption and therefore allow a strategic view as to the achievement of objectives.

The initial work on data mapping and analysis was achieved through the dedicated effort of bringing together staff and systems to allow some initial analysis around consumption and variation which was fairly labour intensive.
We are now building on this initial high level data to enable consumption to be viewed at:

- Populations based on GP practices
- Care Group categories
- By speciality/project level
- Care recipient level

There are several challenges in sustaining this information in order to continue to inform the planning and monitoring process:

- Sustaining the collection of data from different systems to allow the mapping process – this is currently being undertaken by using ISD (currently funded by the Scottish Government) and as this may not be sustainable in the long term work is ongoing locally to develop system work around/data warehousing and the development of dashboards.

- Current process requires confidentiality forms to be completed each time data requires to be accessed for mapping which has led to delays. We are in the process of developing a data sharing protocol with the intention that this is signed off once which will then allow ongoing collaboration. However this is an issue all tests sites will no doubt have encountered and is perhaps something which requires to be addressed nationally.

- Currently the data being mapped relates to health and social care – it does not include data held by General Practitioners. This data would be beneficial to enable a whole picture of the care pathway in terms of interventions, cost and variation. However, it should be stressed that CHPs can have access to GP data which entails putting additional agreements in place, however this tends to be for specific monitoring purposes and is not widely shared.

- GP information was available through QOF+ however this has been replaced by QIP which is considered not to be such a rich source of data. Also, this information although shared with CHP and GP practices, is not widely shared across the health and social care partnerships.

- Tayside is unique across Scotland as they have developed an IT system (MiDiS) which records health community care plans and interventions. As this is rolled out across Tayside this will be a rich source of data to be included within the data mapping process providing a fuller picture of the care pathway.

**Variation Analysis and Models of Care** - As demonstrated within the following charts - The analysis of the joint data highlighted key themes, for example, the high level of expenditure/cost per capita relating to both non-elective admissions to hospital and care homes together with the variation of consumption across different localities. The issues being two fold:

- understanding the reasons for the high level of non elective admissions –
- planned admissions (after extrapolating the impact of socio-economic factors)
- understanding the reasons for the variation in activity and costs when benchmarking across localities (again after extrapolating the impact of socio-economic factors).

*Chart 1 – Health Data*
Chart 2 – Social Work Data

Chart 3 – Health & Social Work Data
As the initial analysis of the joint data was undertaken at a more strategic level it has been difficult to get behind the joint data and provide real evidence as to the reasons for these costs/variations. Nonetheless ongoing work streams have focussed on developing models of care which both look to tackle admissions to hospital and to speed up discharge.

Some examples of good practice to address these issues are:

- The development of virtual wards which involves a collaborative approach with GPs, health and social care professionals to support individuals to manage their long term conditions to prevent escalation and reduce the number of interventions.
- The Dundee Health & Social Care partnership have developed a model of care “Dundee Community Medicine/Early Intervention Pathway” which involves collaborative work across health and care professionals by identifying patients through the use of PEONY2 and other risk factors and putting in place the necessary wrap around care required to prevent admission to hospital.
- Locality models are being developed across the partnerships which involve a collaborative approach not only with health and social care professionals (including GPS and Consultants) but local communities and involvement of the Third Sector.
- Discharge processes continue to be reviewed to ensure early supported discharge from hospitals either through accessing re-ablement services to enable people to return directly to their own homes or by arranging temporary step down care within care homes until such time as the person is fully able to return to their own home.
- The Personalisation agenda together with the development of Self Directed Support will also be crucial to improving the health and the care experience for individuals. This has resulted in changes to the social work assessment process, the focus being on outcomes – concentrating on what people can do – not what they can’t. It also ensures that discussions are held with service users and their families around what options are available to achieve these outcomes rather than providing a menu of the more traditional types of provision such as institutional day care, care home etc.

As previously indicated as data analysis becomes more sophisticated, by being able to analyse data at the care recipient level, this will allow a greater understanding of the various interventions and therefore further inform both streamlining and development of models of care.

**Clinician Involvement** - Due to the nature of the GP contract and the workload of GPs it has been difficult to engage fully with practitioners. That being said, there are good examples of involvement of clinicians in the development of models of care, with monies being allocated to GPs to allow them to provide locum support to free practice time. However, this involvement is dependent on a number of factors i.e. the relationships within the localities, the workload capacity of GPs and the
level of understanding around the concepts of IRF and the benefits it will have for them. GPs are much more interested in local variance and improvement.

Across the partnerships there are differing practices regarding interaction with GPs which involves developing locally enhanced agreements and identifying GPs to take leads for specific areas. This may be leads for particular care groups, specialities or being a lead for a particular locality.

Various representations have been made to the GP sub committee and IRF is a standing item on the agenda which is attended by the IRF Lead Clinician. Within Tayside it is the intention to keep this dialogue open and also to hold both larger consultation/communication events for Tayside and more locally focussed events.

**Financial Mechanisms** - One of the key principles the Government set for IRF was to define local financial mechanisms to allow the flexible use of resources i.e. the resource follows the care pathway. This is being tested out as part of the North West Highland IRF project within Perth & Kinross.

The consumption fund uses the mapped data to provide a picture of consumption. Partners will then be able to consider:

- Whether the patterns of consumption are appropriate to enable achievement of objectives
- Examine the costs per capita and whether the cost and/or the variation is appropriate and offers the best value
- Whether the models of care are appropriate to meet the needs of the locality
- The opportunities to release resources for reinvestment to perhaps preventative care or where opportunities exist for streamlining models of care

The mechanism relies on the ability and flexibility of provider budgets and resources to continuously adjust to follow changing patterns of consumption and to move 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 through the development process this will no doubt highlight a number of challenges e.g.

- Breaking down budgets to a locality level – particular issue within Health
- Development of unit costs
- Setting the right level of accountability/authorisation to transfer resources
- Frequency of monitoring is dependent on the frequency of data mapping
- Frequency of transfer of resources – may lead to cash flow issues – particularly for third sector
General - IRF principles and process are beginning to be used across other areas. For example; Dementia Demonstrator Models; Early Years Services; Mental Health Strategy and Alcohol and Drug Partnerships.

Together with the existing IRF work this has required significant input and commitment of staff to undertake additional work on top of day-today priorities.

GOVERNMENT REDRESS TO BARRIERS

- Data Mapping and Data Sharing
- Need for a national review of data sharing protocols to ensure a consistent approach both locally and nationally in agreeing release and sharing of data
- Consideration in the level of investment required to facilitate either joint IT systems or system work around to allow data sharing i.e. data warehousing and dashboards. Although this is a solution for data mapping, as strategic partnerships develop, this will no doubt highlight bigger network issues. Consideration required as to whether this investment requires to be tackled at a national or local level
- Reintroduce QOF+
- Streamlining of performance frameworks which exist within both Health and Social Care with an emphasis on the value of joint performance measures and the use of IRF
- Mechanisms to support GPs in allowing access to data which would provide the right level of assurance with regard to security and appropriate use of data.

Variation and Models of Care

- Consideration of incentives to facilitate greater clinician involvement
- Issues being experienced require to be linked in the with current review of GP contracts
- Links also required with the discussion paper being developed “A Collaborative Approach to Delivering Primary Care Services in Scotland”
- Greater links and involvement within Secondary Care need to be forged.

Financial Mechanisms

- Health and Social Work have differing financial regulations and schemes of delegation therefore consideration is required as to how these regulations can be bridged.
- Different government funding streams and methods of allocation of funding
- Treatment of VAT – different rules apply.
• Budget setting processes and timescales are not necessarily the same in addition Social Work services have the local political dimension when it comes to setting priorities.

General

• Although the linkages are being made with regard to using IRF principles in the development of various strategies and Change Fund bids, at times the timescales set for creation and submission of strategies are not in line with the ability to provide up-to-date mapping information. This can lead plans to be developed without the benefit of the full integrated picture – particularly in relation to identifying areas of variation.

• The investment by the Government regarding the Change Fund has acted as leverage for change however this has primarily surrounded older people’s services. Perhaps consideration is required for some similar temporary investment to allow leverage to facilitate the wider integration agenda, particularly in recognition of the pressures this may place on developing IT system solutions.

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