

Integrated care in Northern Ireland, Scotland and Wales

Lessons for England

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The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

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Chris has advised the World Health Organization (WHO) and the World Bank and has served as a consultant to governments in a number of countries. He is an honorary fellow of the Royal College of Physicians of London and of the Royal College of General Practitioners, an honorary professor at the London School of Hygiene & Tropical Medicine, and a companion of the Institute of Healthcare Management.

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In 2001 she received a Distinguished Teaching Award and in 2006 a prestigious National Teaching Fellowship by the Higher Education Academy. In 2008 she secured an ESRC fellowship and spent nine months as policy adviser in the Office of the First Minister and Deputy First Minister. In 2011 she was appointed by the health minister to join a five-strong panel of experts to oversee a radical review of health and social care in Northern Ireland. In 2012 she was appointed to the Irish President's Council of State as one of the seven personal nominees of President Michael D Higgins.

David R Steel was Chief Executive of NHS Quality Improvement Scotland from its creation in 2003 until 2009 and played a major part in setting up the Scottish Patient Safety Programme. After 12 years as lecturer in public administration at the University of Exeter, he became Assistant Director of the National Association of Health Authorities in 1984. From 1986 he held various senior posts in NHSScotland and the Scottish Office Health Department. In retirement he has held an honorary senior research fellowship at the University of Aberdeen and chairs the Prioritisation Panel of the National Institute for Health Research Health Services and Delivery Research Programme. He is the author of the Scottish health system review published in 2012 as part of the European Observatory's *Health Systems in Transition* series. In 2008 he was awarded an OBE for services to health care.

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Introduction

Chris Ham, Chief Executive, The King's Fund

The aim of this report is to describe the approach taken to integrated care in Northern Ireland, Scotland and Wales with a view to drawing out the lessons for England. The report has been written at a time when policy-makers in England have made a commitment to bring about closer integration of care both within the NHS and between health and social care. This creates an opportunity to understand what has been done in the other countries of the United Kingdom to develop integrated care in order to inform policy and practice in England.

With this in mind, we commissioned authors in each of these countries to write a paper covering the following issues:

- the context in which health and social care is provided including the governance and planning of these services and organisational arrangements
- policy initiatives to promote integrated care pursued by the devolved governments, and the impact of these initiatives
- the barriers and challenges to achieving integrated care, and how these have been tackled and overcome.

We also invited the authors to reflect on what England could learn, drawing on their own experience and assessment of what has and has not been achieved in the country that they were asked to write about.

Early drafts of the papers were discussed at a seminar with the authors and this provided an opportunity to identify similarities and differences and emerging themes. Further drafts followed and these were then reviewed by experts in integrated care both within The King's Fund and outside. The papers published here have incorporated comments on these drafts, and provide comprehensive and up-to-date descriptions of the experience of Northern Ireland, Scotland and Wales and the lessons that can be drawn from this experience.

While the papers follow a broadly similar format, based on the brief given to the authors, there is some variation in the issues covered and the analysis offered by the authors. This reflects differences in the data sources that were drawn on in preparing the papers and in the availability of evidence in each country. The final section of this report offers an overview of the three countries and has been written to compare and contrast their experience and explicitly to identify lessons for policy-makers and practitioners in England.

This report was written in parallel with an analysis of health policy in the four countries of the UK written by my colleague, Nick Timmins. As Nick emphasises, there is enormous potential for countries to learn from each other but in practice this rarely happens. The natural experiments that have emerged since devolution have accentuated pre-existing variations between countries but policy-makers have shown little interest in studying these variations and learning from them. This report is a modest attempt to encourage greater curiosity and lesson learning in the hope that others may see its value and follow our example.

1 Northern Ireland

Deirdre Heenan, Pro-Vice-Chancellor (Communication)
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Introduction

Integration in health and social care is not a new concept and has been an explicit policy goal of successive UK governments over the last two decades. A wide range of initiatives and strategies have been introduced to facilitate integrated working, including joint working, partnerships, pooled budgets and structural integration. The focus on integration has become a political preoccupation due to the growing pressure on the NHS, which has amplified the fragmentation and duplication that exist within the system and highlighted the need to ensure that a sustainable model of care is developed and implemented.

There is widespread acceptance that an integrated system of health and social care can lead to better outcomes for service users, particularly for older people with complex needs. Uniquely though, within the United Kingdom, Northern Ireland has had a structurally integrated system of health and social care since 1973. Significantly, the original decision was not informed by theoretical models of health care, but by an urgent need to reorganise the system of local government, which had become widely discredited. There was little awareness that this model of reorganisation, which was given a cautious, lukewarm welcome by health care professionals, would become viewed by many policy-makers, politicians and academics as the Holy Grail.

As this chapter will outline, policy developments in Northern Ireland from the late 1960s have taken place in a distinct context of 30 years of civil and political unrest and direct rule governance. Devolution was restored in 1998 to the locally elected Northern Ireland Assembly; however, following a political crisis it was suspended between 2002 and 2007 and direct rule was reinstated. While devolution has been in place continuously since 2007, this uncertain, volatile landscape has formed a challenging backdrop for the reform and modernisation of health and social care.

Context: the health and social care system

Social context

Northern Ireland has a population of approximately 1.8 million people, with two-thirds of these located around the capital city in the Greater Belfast area. Historically, the Northern Ireland economy has been dominated by manufacturing industry and agriculture, but there has been a shift over the last 30 years to a more service-based economy. The largest elements of the private sector in Northern Ireland are wholesale and retail, manufacturing, and business and professional services (real estate and renting, and business activities). Local and regional statistics have invariably confirmed that Northern Ireland is one of the most deprived regions of the United Kingdom, with relatively high levels of unemployment,

disability and poverty. It has the lowest wages and one of the lowest labour productivity rates, and it is heavily reliant on the public sector, which is coupled with a weak private sector. These weaknesses reflect a number of unique, interrelated factors, not least the legacy of 30 years of conflict, the demographic structure and the peripheral location of Northern Ireland, as well as issues surrounding deprivation and rurality.

Northern Ireland is experiencing major demographic shifts: the Northern Ireland Statistics and Research Agency has projected the population to rise from 1.8 million in 2010 to nearly 2 million in 2025 (an increase of almost 8 per cent). They also project that over the same 15-year period, the number of people aged 65 and over will increase by 42 per cent, from 260,000 to 370,000. Significantly, though, the number of people of working age is projected to increase by only 1.4 per cent, from 1,109,000 to 1,124,000, by 2025. The projected figures for people aged 85 and over make dramatic reading: by 2025 the number will increase by 25,000 to 55,000 of whom 62 per cent will be women. The over-85 population will double by 2027 compared with 2010 (Department of Health, Social Services and Public Safety 2013).

Overall life expectancy in Northern Ireland has continued to increase over the period 1980–2009 (O'Neill *et al* 2012). However, there are increasing numbers of people with chronic conditions such as diabetes, respiratory problems, stroke and obesity. In Northern Ireland as in other parts of the United Kingdom, there are increasing expectations and rising demand for use of new drugs and technologies. Research has highlighted a predicted funding gap of £600 million by 2014/15 in a budget of about £4.5 billion, alongside a system of health and social care that over-invests in an inefficient hospital sector while under-investing in community, primary and mental health services (Department of Health, Social Services and Public Safety 2012).

Political context

The Northern Ireland Assembly was established as a result of the Belfast Agreement of 10 April 1998. The Agreement was the outcome of a long process of talks between the Northern Ireland political parties and the British and Irish governments. The Agreement was endorsed through a referendum held on 22 May 1998 and subsequently given legal force through the Northern Ireland Act 1998. The Northern Ireland Assembly has full legislative and executive authority for all matters that are the responsibility of the Northern Ireland government departments and which are known as transferred matters. Excepted matters remain the responsibility of the Westminster parliament. Reserved matters are also dealt with by Westminster, unless it is decided by the secretary of state that some of these should be devolved to the Assembly. Excepted and reserved matters are defined in the Schedules to the Northern Ireland Act. The Assembly was elected on 25 June 1998 under the terms of the Northern Ireland (Elections) Act 1998.

The Northern Ireland Assembly consists of 108 elected Members, six from each of the 18 Westminster constituencies. Its role is primarily to scrutinise and make decisions on the issues dealt with by government departments, and to consider and make legislation. The Assembly is a coalition government based on an agreed formula for power sharing. A First Minister and a Deputy First Minister lead an elected 11-person executive committee of ministers, each responsible for a separate government department.

Since its establishment in 1998, the Assembly has been suspended on four occasions; during these periods legislative power was returned to Westminster on all matters and, as previously, Northern Ireland was governed by the Secretary of State for Northern Ireland.

The United Kingdom's devolved administrations are, for the most part, financed by what is known as a block grant and formula system. The block grant is set by the UK government for multi-year periods. The current block grant covers the four years 2011/12 to 2014/15. The departmental expenditure limits are fixed for each year of the period. Due to HM Treasury rules, the Northern Ireland Executive cannot shift resources from one year into another. The money comes from general taxation across the United Kingdom. The size of the block grant is determined through a mechanism known as the Barnett Formula: as spending on a certain policy area in England goes up or down, Northern Ireland receives an equivalent population-based share of the funding.

Consequently, the amount of money that Northern Ireland receives through the block grant is a direct result of decisions to spend (or not to spend) on programmes that are comparable with England (but not, for example, defence spending, which is all controlled at the UK level). Ultimately, how the money is spent is a local issue depending on priorities. The Executive is not tied to spending it on any particular functions and does not have to mirror England. The block grant is distributed by the Executive among the various government programmes. The Department of Health, Social Services and Public Safety (DHSSPS) receives the largest single allocation of more than £3.8 billion each year, which accounts for almost 45 per cent of total public expenditure.

Historical context

Northern Ireland has had a long history of devolution within the United Kingdom, going back to 1921. The Northern Ireland parliament governed for 51 years, from the foundation of the state until the imposition of direct rule in 1972; it was the single longest-running scheme of governance in the province's history. In 1972, in response to a period of sustained violence and the apparent unwillingness of local politicians to share power, direct rule was introduced. This meant that public and social policy decisions were taken at Westminster and communicated through a secretary of state within the Northern Ireland Office, who answered directly to parliament. They in turn appointed a minister for health, who was responsible for health and social care.

The introduction of direct rule in 1972 coincided with the reorganisation of local government. The new structure was established under the Local Government Act (Northern Ireland) 1972 and became operational in 1973. It consisted of a single tier of 26 district councils based on the main population centres. A key feature of this reorganisation was that local government was divested of its key responsibilities such as health, personal social services, housing and youth education, which were transferred to statutory boards. Despite a number of reviews and reorganisations, local government functions have remained extremely limited (Birrell 2009).

Integrated health and social care

Northern Ireland has had an integrated structure of health and social services since 1973. The original decision owed more to a requirement to reorganise local government than any thought-out, evidenced-based strategy on integration. A radical restructuring of local administration in Northern Ireland was first mooted in a 1969 parliamentary Green Paper, *The Administrative Structure of Health and Personal Social Services in Northern Ireland* (Government of Northern Ireland 1969). A review body reported in June 1970, and in 1972 the shape of the new structure was outlined in a report by the appointed management consultants.

The rationale behind the restructuring was declared as being ‘the improvement of the provision of health and social services to the community in Northern Ireland through establishing an integrated approach to the delivery of hospital and specialist services, local authority health and welfare services’ (Government of Northern Ireland 1969). The changes would, it was hoped, provide a more rational and comprehensive structure in which to decide priorities, develop policies and ‘work together toward a common goal of meeting the total needs of individuals, families and communities for health and social services’ (Government of Northern Ireland 1969). These dramatic changes took place against a backdrop of social and political unrest. It has been contended that, rather than as a means of delivering more efficient and effective services, structural changes were introduced as a reaction to the political turmoil and were an attempt to exert control and stability by removing power from discredited elected representatives and placing it in the hands of appointed bodies (Birrell and Murie 1980).

The proposed integration under a structure of four area boards received ‘remarkably little discussion’ in the Green Paper apart from brief references to the need for co-operation and joint planning (Heenan and Birrell 2011, p 55). The Permanent Secretary of the Department of Health and Social Services, speaking in 1971, identified some of the main advantages of the new system as making possible comprehensive planning at every level, encompassing the totality of medical and social care, and ensuring public participation. Until reform in 2009, health and social services were delivered in Northern Ireland by four health and social services boards, organised on a geographical basis, and eighteen trusts. Of these, eleven were community health and social services trusts and seven hospital trusts based largely on acute general hospitals. A separate ambulance trust and 37 other quangos were involved in the delivery and administration of care.

During the period of direct rule (1972–99), reform and the development of policy and strategy in health and social services were virtually non-existent. The default position was to copy English policy changes, and the UK government appeared content to keep this unusual system of governance ticking over. Stability was the key priority, and social and public policy reform was generally sidestepped by direct rule politicians.

To some onlookers this may appear rather surprising. Direct rule health ministers were in a somewhat unique position in that they were not directly accountable to the local electorate and could have taken medically necessary but politically unpopular decisions. The absence of local political accountability, known as the ‘democratic deficit’, could have made Northern Ireland’s health service a fertile ground for innovation and modernisation. Perhaps unsurprisingly, it was quickly apparent that direct rule ministers were unwilling to make politically contentious decisions.

Northern Ireland, it appeared, already had sufficient political controversy without adding health and social care reform to the mix. Importantly, direct rule was also largely viewed as a short-term stopgap with a devolved administration just around the corner, so it was considered best to leave the more controversial decisions to local politicians and pointless to embark on long-term projects. Consequently, health and social care in Northern Ireland largely stagnated under the period of direct rule, and there were few, if any, attempts to pursue distinctive policy approaches based on the needs of the local population.

The lack of progress with regard to social policy-making is clearly reflected in a number of key areas. In the area of social care, Northern Ireland continues to operate under the vision and principles set out in the 1990 White Paper, *People First: Community care in*

Northern Ireland. Community care has been neglected, under-developed and under-funded, and requires a radical review. The persisting levels of deprivation and the legacy of Northern Ireland's 30 years of social and political unrest, known as 'the troubles', have contributed to the significant mental health issues. In September 2005, *Equal Lives: Review of mental health and learning disability (Northern Ireland)* (known as the Bamford Review) set out proposals to reform services in this area. To date, however, progress has been slow and uneven. In 2011 it was reported that levels of mental health problems were 25 per cent higher in Northern Ireland than in Great Britain but funding was 25 per cent lower.

Amended mental health legislation and new mental health capacity legislation are still pending. Legislation has not been updated since 1986, a situation which contrasts sharply with the one in Scotland. The Bamford Review stressed the need to develop the advocacy role, but again little progress has been made in this area.

The resumption of devolution in 2007 initially delivered very little progress in the area of health and social care. Despite the unassailable case for substantial reform and reconfiguration, local ministers appeared unwilling or unable to grasp the nettle, sure in the knowledge that any proposed changes would be met by local opposition. The first Health Minister, Bairbre de Brún (Sinn Féin), seemed unwilling to accept that major reform was required, despite the historic over-reliance on hospital services and an under-developed system of community care. She was followed by Michael McGimpsey (Ulster Unionist Party), who was apparently aware that there were major problems but focused his attention on the implementation of the Review of Public Administration (RPA) and its accompanying restructuring.

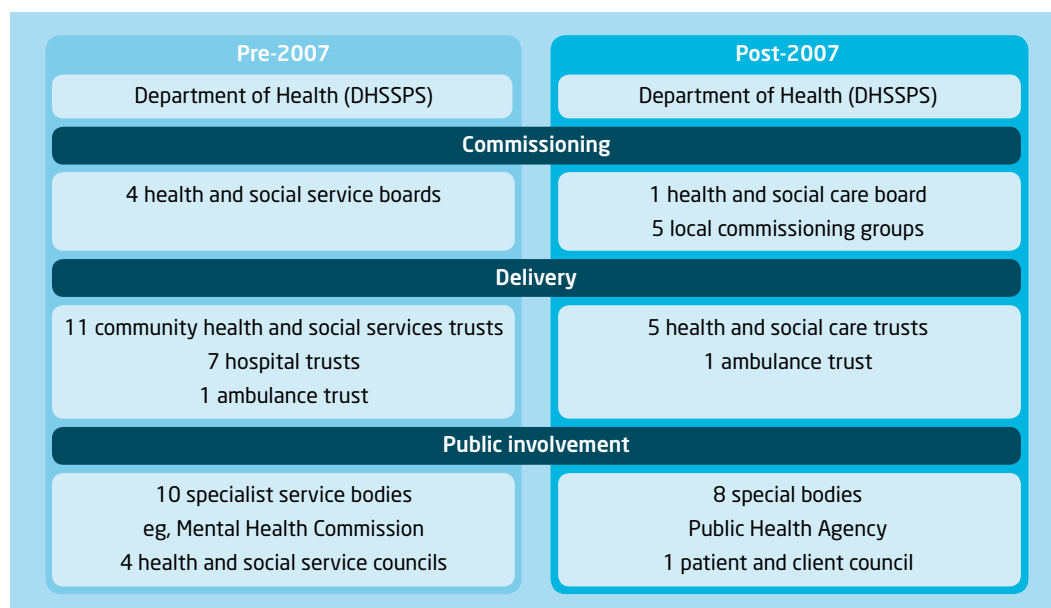
Two substantial reviews of Northern Ireland's health and social care system (Appleby 2005, updated in 2011; Connolly *et al* 2010) have attempted to assess how the system compares with other countries of the United Kingdom. These reports and a recent National Audit Office report (NAO 2012) highlighted the difficulties of any attempt at cross-national comparisons due to the use of different indicators and changes over time. In his 2005 report, Appleby bemoaned the distinct absence of an explicit performance management system. He regarded it as pivotal to achieving improvements in efficiency, effectiveness and responsiveness. He was critical of the existing performance management structures and suggested (p 10) that they contributed to an impression of 'a system lacking urgency, of general drift, and a consequent frustration amongst many in the services – at all levels – with the relative lack of improvement in performance'. He contended that the current performance management system was devoid of the clear and effective structures, information and, most importantly, incentives – both rewards and sanctions – at individual, local and Northern Ireland organisational levels to encourage innovation and change.

Perhaps illustrative of the complexity and challenges inherent in the system, despite it being the largest portfolio in monetary terms, the health portfolio has not been viewed as a top priority for political parties. Edwin Poots (Democratic Unionist Party) became health minister in May 2011 and from the outset acknowledged the need for radical change in order to optimise outcomes. In June 2011, he announced that a major review of the provision of health and social care services would be undertaken. Making the case for change was at the centre of this review and a fundamental recognition that the existing model of care that had developed for the most part under direct rule was not fit for purpose (*see* p 9–10).

Organisation of health and social care in Northern Ireland

The Health and Social Care (Reform) Act (Northern Ireland) 2009 was introduced following the RPA to reduce the number of bodies involved in the administration, commissioning and delivery of health and social services. While Northern Ireland has had structural integration of health and social care since the early 1970s, this further major restructuring aimed to maximise economies of scale and improve outcomes. This Act created a single large commissioning body, the Health and Social Care Board, and five large health and social care trusts (HSC trusts) responsible for the delivery of primary, secondary and community health care. Co-terminous with the new trusts were five local commissioning groups (see Figure 1 below).

Figure 1 Structures for health and social care delivery, Northern Ireland



Department of Health, Social Services and Public Safety

With overall authority and allocation of government funding, DHSSPS is one of 11 Northern Ireland government departments created in 1999 as part of the Northern Ireland Executive. Health and social care is one of the three main business responsibilities of the department, which are:

- health and social care, which includes policy and legislation for hospitals, family practitioner services and community health, and personal social services
- public health, which covers policy, legislation and administrative action to promote and protect the health and wellbeing of the population
- public safety, which covers policy and legislation for fire and rescue services.

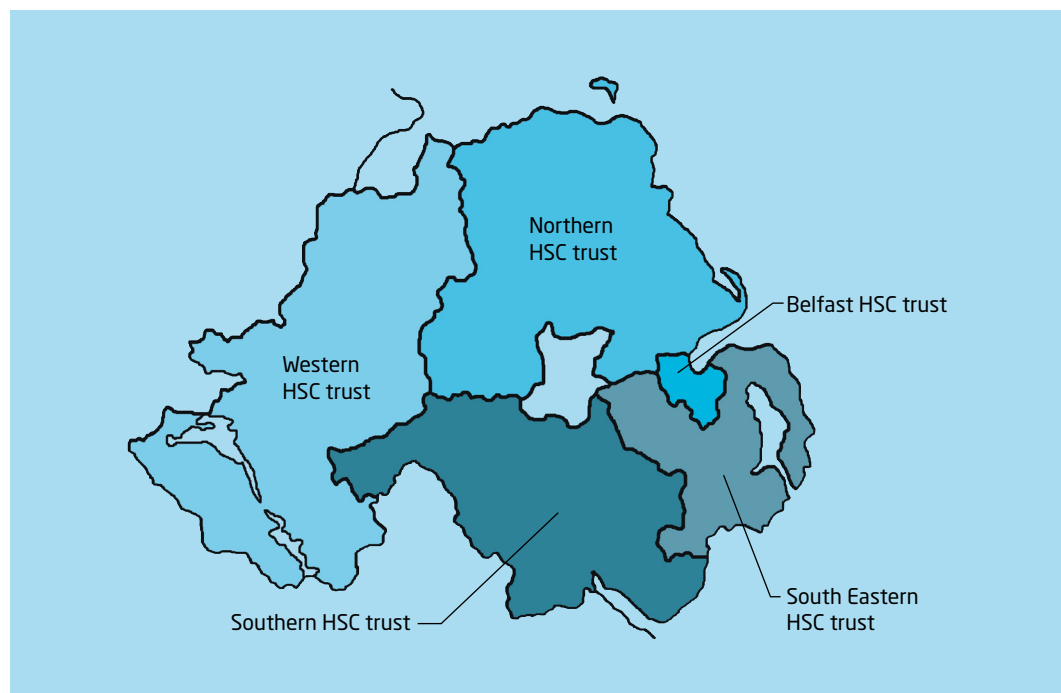
The department is responsible to the Minister for Health, who is one of the 11 departmental ministers in the Executive. A cross-party health committee performs a scrutiny role in terms of the decisions made by the minister, the operation of the department, and other health and social care bodies and functions.

Health and Social Care Board

The Health and Social Care Board (HSCB) sits between the department and the trusts and is responsible for commissioning services, managing resources and performance improvement. The board is also directly responsible for managing contracts for family health services provided by GPs, dentists, opticians and community pharmacists. These are all services not provided by HSC trusts.

Inside the board there are local commissioning groups focusing on the planning and resourcing of services. These groups cover the same geographical area as the HSC trusts, as shown in Figure 2 below. The structure of health and social care in Northern Ireland is shown in Figure 3 opposite.

Figure 2 Health and social care trusts, Northern Ireland

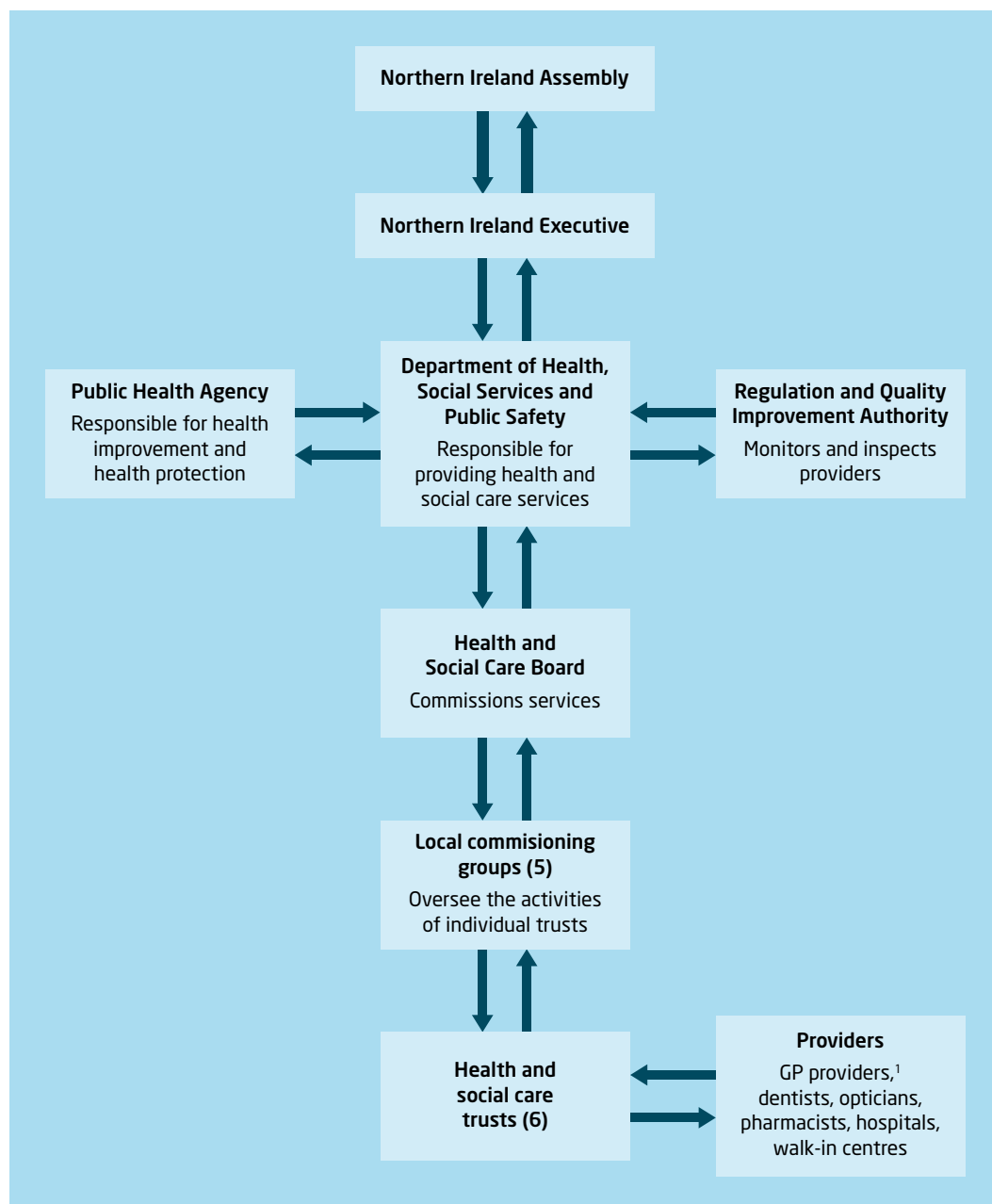


Source: Belfast Health and Social Care Trust

Health and social care trusts

The five HSC trusts provide health and social services across Northern Ireland on a geographical basis. A sixth trust, the Ambulance Service, serves a particular function and operates on a regional basis. While the HSCB commissions services, it is the trusts that actually provide them 'on the ground'. Each trust manages its own staff and services, and controls its own budget. The average population per trust is 359,878 (compared with 307,753 in England).

GPs play a key role in the system, as they are usually the first point of contact with service users and act as gatekeepers to other services. Usually GPs work in group practices, often in teams that include health visitors and nurses. The vast majority of health care services are available through the public sector, with just two small private hospitals. The majority of residential home places are provided by the private sector.

Figure 3 Structure of health and social care, Northern Ireland

¹ GPs in Northern Ireland are contracted directly by the Health and Social Care Board and so they receive funding from, and are directly accountable to, the board rather than the health and social care trusts.

Source: Northern Ireland Audit Office

Transforming Your Care

In 2011, Edwin Poots, Minister for Health, Social Services and Public Safety in Northern Ireland, launched a review of health and social care services, which was to undertake a strategic assessment of the system and bring forward recommendations for the future shape of services with an implementation plan. *Transforming Your Care: A review of health and social care in Northern Ireland* (the Compton Review) was published in December 2011 (Department of Health, Social Services and Public Safety 2011b). Described as the biggest shake-up of health care in the region's history, it concluded that doing nothing was not an option, as the current and future pressures on the health and social care

system provided an unassailable case for change. It identified a clear mismatch between the needs of the population for proactive, integrated and preventive care for chronic conditions, and a health care system where the majority of resources are targeted at specialised, episodic care for acute conditions. The report set out a vision for the future of health and social care in Northern Ireland which ensured safe, sustainable, effective services for all. It advocated:

- a reduction in the number of acute hospitals from ten to between five and seven
- a shift of 5 per cent of hospital funding to primary and community care
- a shift of work from hospitals to community and primary care
- an increased role for GPs in the commissioning and provision of services
- an emphasis on prevention, focusing on obesity, smoking and alcohol
- a shift towards greater care at home
- a robust, bottom-up commissioning structure
- future planning for telemedicine
- the personalisation of care.

The Compton Review set out integrated care and working together as one of the key principles. This was justified in terms of a need for improvement, expressed as: ‘different parts of the health and social care system should be better integrated to improve the quality of experience for patients and clients, safety and outcomes’ (Department of Health, Social Services and Public Safety 2011b, p 40). There was little analysis or evaluation of the failings of existing integration, but there were implied criticisms in comments such as ‘the professionals providing health and social care services will be required to work together in a much more integrated way to plan and deliver consistently high quality care’ (Department of Health, Social Services and Public Safety 2011b, p 7), and an expression of concern at the slow implementation of new integrated services for learning disability (Department of Health, Social Services and Public Safety 2011b, p 94). It highlighted the over-reliance on hospitals and noted the need to deliver care closer to home; evidence for this included a bed utilisation audit of 2011 which showed that, on the day in question, up to 42 per cent of the inpatients reviewed should not have been in hospital.

Figure 4 Key trends in location of services, Northern Ireland



Source: Cole (2009)

The proposal for integrated care partnerships

As part of a future model for integrated health and social care, a key proposal is to establish integrated care partnerships (ICPs) to join together the full range of health and social care services in each of 17 areas, including GPs, community health and social care providers, hospital specialists, and representatives of the independent and voluntary sectors. It is envisaged that the ICPs will have a role in determining the needs of the local population, and planning and delivering integrated services. Crucially, it is suggested that these ICPs have the potential to make a positive contribution to the delivery of care closer to home, rather than in hospitals. It is stated that GPs will assume a critical leadership role in these groups (Department of Health, Social Services and Public Safety 2011b, p 123).

This proposal may seem surprising given the existing integrated structures, and it raises questions about the relationship of ICPs to integrated programmes of care, integrated teams, integrated budgets, decision-making powers, and the relationship with commissioning and provider arrangements. Following the publication of the Compton Review, detailed plans for the implementation of the Transforming Your Care agenda were drawn up by the five HSC trusts, which added some of their own interpretations to the proposals. Subsequently DHSSPS has published its own implementation paper, which provides some more detail about ICPs (Department of Health, Social Services and Public Safety 2012).

ICPs are described as a co-operative network between existing providers, that will design and deliver high-quality services and will be clinically led (Department of Health, Social Services and Public Safety 2012, p 22). It is expected that much of the initial focus of ICPs will be on improving key aspects of the way services are organised for frail older people and for those with specific long-term conditions such as diabetes. ICPs will prevent hospital admission by identifying patients most at risk, and will work proactively across the sector to develop strategies to manage health and social care needs. It is suggested that working in this 'more integrated way' will reduce or prevent hospital admissions.

Some trusts, however, have expressed their concerns over proposals to develop these ICPs. Particular issues raised included:

- that the creation of 17 new stand-alone bodies appears excessive and will lead to increased bureaucracy and overhead costs
- a scepticism about the resourcing of models of care in the community in the light of increasing demands
- that fixed professional membership could lead to a rigid approach and consequently membership should be fluid
- the possibility of creating new silos rather than facilitating more co-operation
- that the focus of these ICPs should be on patient pathways.

Implementing Transforming Your Care

In the implementation of Transforming Your Care, the focus on better integration between hospitals and GP practices tends to mean that little attention is paid to the continuing developments in integrated social and health care in Northern Ireland. There are numerous well-established examples of how a holistic approach providing care closer to home rather than in a hospital setting can improve service users' outcomes and reduce demand on the NHS. Policies to move resources from hospital care to home- and community-based care are being implemented throughout the United Kingdom. The Northern Ireland model of structural integration can be assessed for its

potential and capacity to deliver on these goals and objectives. The need in Britain to bring those providing acute hospital services more into integrated working has been recognised (Ham 2009). The impact of different professional philosophies and cultures between the community and acute sectors has been a constant theme in research literature (Cameron *et al* 2012).

The Transforming Your Care implementation plans do carry with them risks for the successful and effective integration of social care with acute care. The Belfast HSC Trust (2012) has clearly identified a number of overall risks, including the assumptions about cash release from the acute sector and the change in demand for services not being realised, lack of financial resources, lack of capacity/capability in the workforce, lack of IT links and physical infrastructure, and lack of clinical engagement and commitment to deliver collectively on the implementation plans. The treatment of social care in the implementation plans can be seen as problematic. The plans may create a very unequal relationship between health and social care in terms of the composition of partnership committees and the leadership of partnerships. The planned shift from hospital care to health care in the community could undermine the position and role of adult social care and have adverse consequences on the allocation of resources.

There is a tendency in the implementation plans to define people's needs in terms of health attributes and the management of illness. It has been noted that a focus on reablement and getting people back on their feet can lead to a neglect of other social care support and measures to enhance wellbeing (Glendinning and Means 2004). The plans for the implementation of Transforming Your Care pay little attention to modernisation agendas for adult social care as developed in England, Scotland and Wales. The theme of user involvement and user control is largely ignored, despite its prominence in British narratives as a key to better quality and outcomes.

Personalisation was strongly advocated throughout the Compton Review, but is not discussed in detail in the Belfast HSC Trust's plans or the Department's implementation strategy, beyond the low-key definition of personalisation. It can be argued that if there is a shift from hospital care to a greater reliance on social care, more developed strategies would be needed relating to support for the enhanced role for carers, new workforce developments and specific outcome frameworks to measure transformation other than through changes in service provision. Overall there is also a need for new social services legislation, akin to the Bills for England and Wales, which builds on the knowledge that has been acquired since the inception of direct payments. This legislation would clarify and enshrine the rights of service users.

Critical to the success of the Transforming Your Care agenda is mobilisation of a cross-departmental policy network that supports the entire public policy agenda and ensures that there is joined-up thinking in the design and delivery of health care. Welfare payments, housing and transport are crucial elements of any comprehensive strategy, yet they sit within completely separate government departments. Previous research (Trench and Jeffrey 2007, p 24) noted that the extent to which responsibilities are spread across government departments means that Northern Ireland has 'the most disjointed and limited approach to ageing issues in the UK'. Clearly, this issue of a cross-departmental approach is one that must be afforded priority, yet it is one which has not yet been considered or discussed at Executive level.

Research on integration in Northern Ireland

A striking aspect of the system in Northern Ireland is the lack of rigorous evaluation and assessment, despite the fact that closer integration has been a key policy objective of successive British governments for decades. A range of methods and initiatives to facilitate closer working, including partnerships, have been introduced and piloted, yet scant attention has been paid to the system in Northern Ireland. Heenan and Birrell (2006, 2009) highlight this anomaly and noted the following.

Despite the uniqueness of the structure, it has received surprisingly little attention from policy analysts and academics. On the rare occasion where work on the integration of health and social services has referred to Northern Ireland, comments have tended to be somewhat dismissive of any beneficial achievements, without any substantial evidence to support this view.

(Heenan and Birrell 2006, p 49)

Policy documents from DHSSPS and sessions of the Northern Ireland Assembly Health Committee with senior civil servants pay little attention to the potential of integration. Among politicians, policy-makers and academics there continues to be a lack of understanding of the unique structures in Northern Ireland and the possibilities that they present. The challenge of achieving a holistic system of care across the spectrum of needs is an international one; this model of health care could provide important insights, but it requires robust evaluation and assessment. Despite the continuing support for integrated approaches, there is surprisingly little interest in strategic review.

Heenan and Birrell (2006, 2009, 2012) have published a number of small-scale reviews of the integrated system and highlighted the benefits and limitations of the system in Northern Ireland. The operation of the integrated structure has delivered benefits through programmes of care. The integrated management system allows for the cultural gap between health and social care to be effectively addressed. Reduced delays in hospital discharge have also been identified as a key advantage of this integrated system. In their research, Heenan and Birrell (2009) also identify a number of areas that continue to cause difficulty, including the dominance of health care over social care and the absence of inter-professional training. These advantages and disadvantages are now considered in more detail.

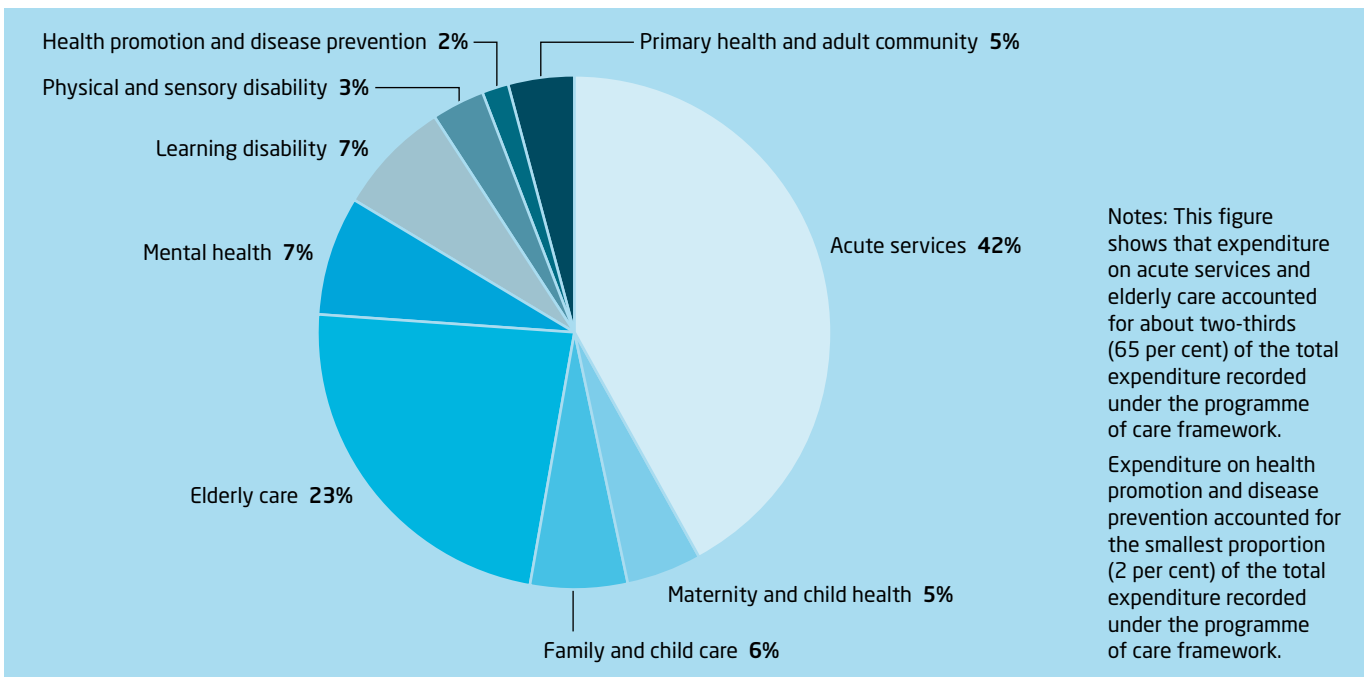
Achievements of structural integration

Delivery of integrated care

Integration in the delivery of services in Northern Ireland is mainly achieved through the division of health care into programmes of care to which resource procurement and finance are assigned (*see* Figure 5 overleaf), so as to provide a management framework. They are used to plan and monitor the health service by allowing performances to be measured, and targets set and managed on a comparative basis. They follow a similar pattern in all trusts. There are nine programmes of care: acute services; maternity and child health; family and child care; elderly care; mental health; learning disability; physical and sensory disability; health promotion and disease prevention; and primary health and adult community. The programme of care teams operate on an inter-disciplinary basis, but the degree of integration does vary between the programmes. Mental health and learning disability are the most fully integrated, with child care reflecting least integration, due largely to statutory commitments.

Heenan and Birrell (2009) highlighted extensive professional support for this method of working as it was claimed it ensures that resources are used to best effect and managers

Figure 5 Breakdown of HSC trust expenditure by programme of care, Northern Ireland, 2009/10



Source: Northern Ireland Assembly (2011)

are not constrained by artificial boundaries between health and social care. Programmes of care appear well placed to meet the increasingly complex needs of service users. Also, within this approach the individual has a named key worker and this makes access to services less complex and daunting. Care is co-ordinated and therefore duplication of services is avoided. This has been referred to as a ‘one-stop shop’ or ‘no wrong door’ approach. The fact that there is one point of entry for anyone wishing to access health and personal social services is considered to be a particular advantage of the system. The structural integration is thought to provide a seamless service which avoids fragmentation and duplication and ensures that service users do not slip through the net.

In Britain, the Care Programme Approach (CPA), which is similar to these programmes of care, was introduced in 1991 to improve collaboration and multidisciplinary working. The CPA has improved multidisciplinary working in services for older people and those with mental health problems but has not led to a fully integrated service (Snape 2003). In their discussions on modernising the NHS, Plamping et al (2000) claimed that many people shared the government’s aspiration for further co-operation but inter-agency tensions would not simply go away. Partnerships between organisations are difficult to achieve, as departmental, cultural and organisational differences are hard to overcome. The key difference in Northern Ireland is that there is one agency, one employer, one vision, shared aims and objectives, and one source of funding, and consequently many of the problems identified in Britain have been avoided.

Integrated management

Integrated management has been highlighted as a key achievement of the integrated health and social care structure. It is common in all programmes of care, with the exception of child care, for the position of programme manager or team leader to be open to a range of professions. Thus, a social worker may lead a team involving nurses on a mental health team, or a nurse may lead a team including social workers on an older

person's care team. This approach is designed to ensure that all professions are equally valued and respected. It recognises the fact that each profession brings with it its own insights, traditions and values. A 'parity of esteem' model afforded to each profession gives everyone involved the opportunity to take the lead in management. Clearly, though, within this model it is essential that individual professional competencies are maintained and enhanced, and that all staff have a right to professional supervision.

This management structure enables and encourages health care professionals to move across to management roles, and a clear benefit of the integrated structure is that it widens the pool of potential managerial talent. Significantly, while there is integration in day-to-day service delivery, core professional training is still separate. This remains a significant weakness of the system in Northern Ireland. However, multi-professional training and staff development are a feature of work within the trusts, with courses offered on a range of subjects such as needs assessment, case planning, working with children who have been sexually abused, child protection training and courtroom skills.

Hospital discharges

An efficient and timely system of hospital discharge is perceived as one of the real benefits of the integrated structure. In integrated trusts a single body is responsible for discharge and arranging care outside the hospital. Rather than having two agencies debating over responsibilities and costs, a holistic response to individual needs is possible. This facilitates long-term strategic planning for the needs of service users. Systems have been designed to ensure a smooth interface between acute and community services. Strategic decisions are relatively straightforward. For example, when hundreds of long-stay patients with learning disabilities were transferred into the community, there was no need to set up joint management meetings with local authorities. The fact that the move was being overseen by one agency meant that it could happen relatively quickly.

Henwood and Wistow (1993) observed that in Britain there were inherent tensions between health and social care agencies and that this had a detrimental effect on hospital discharge. These conflicting perspectives about what constituted success could impact on patient care. Facilitating the move from institutional to community care, particularly in phasing out provision in relation to psychiatric hospitals and special care institutions, has been identified by those involved as a major achievement of integration in Northern Ireland. Integration has made it easier to close down such institutions, and to prepare for discharging patients into the community.

A social worker who had been appointed as a team leader in a community stroke rehabilitation team was in no doubt that the organisational arrangements were beneficial to the service user. The use of a single assessment system was also highlighted as a key to the successful transition from hospital to the community: care managers co-ordinate assessments involving multiple agencies and professionals. Information and expertise are shared in a way that is mutually beneficial. However, it should be noted that in the area of mental health and learning disabilities the targets set by DHSSPS for resettlement have not been achieved. Clearly, having structures in place to enable a smooth transition to community care and avoid conflict between health and social care agencies does not ensure that targets are met, and the area of mental health is often not viewed as a priority within trusts.

In 2012 an audit report on health care across the United Kingdom found limited availability and consistency of data across the four countries, restricting the extent to which meaningful comparisons can be made between the health services (National Audit Office 2012). Comparable data on the efficiency and quality of health care is patchy.

Consequently, without a single overarching measure of performance, the report was unable to draw firm conclusions about which health service is achieving the best value for money. Where comparative data is available, it found that no one country has been consistently more economic, efficient or effective across the indicators that were considered.

Research from Scotland on delayed discharge (Joint Improvement Team 2011) highlighted the difficulties of attempting to make comparisons across the countries of the United Kingdom. It noted that performance in Northern Ireland has often been held up as exemplary. A single, unified health and social care system might help to alleviate many of the issues, but it is difficult to make comparisons because of the different data collected. In Northern Ireland discharge delays are only counted from acute hospitals; mental health and learning disability discharges are excluded. However, there are very tight targets:

- 90 per cent of patients with ongoing complex care needs will be discharged from an acute setting within 48 hours of being medically fit, and no complex discharge will take longer than 7 days – in all cases with appropriate community support. (A complex discharge is one that can only take place following the implementation of significant (7 hours or more) home-based or other community-based services, including residential or nursing home services.)
- All other patients will be discharged from hospital within six hours of being declared medically fit, including all patients requiring reactivation of an existing care package, non-complex care packages or equipment provision.

These targets are generally achieved with a compliance rate of around 95 per cent.

However, most patients are transferred to intermediate care beds or post-acute settings, at which point there is no ongoing data collected on the patients. In other words, the vast majority of delays in Scotland would not be registered in Northern Ireland. In Northern Ireland, data is not collected for the complete patient journey and therefore some of the available statistics can be misleading. For example, in a number of trusts it is common practice for a patient to be moved from a bed in an acute hospital to a residential home while they are assessed. How long they stay in this setting and where they move on to is unknown.

There is some evidence to suggest that the larger, fully integrated HSC trusts in Northern Ireland have addressed some of the perennial issues around delayed discharges, and an efficient system is viewed by many as one of the real benefits of the integrated structure. The Southern HSC Trust reported that the number of delayed discharges has been significantly reduced, and in a similar vein the Belfast HSC Trust described improvements in discharge delay as very significant. The Northern HSC Trust has reported that it has been able to meet its target of effecting discharge from hospital within 48 hours for 90 per cent of people with complex needs and within 7 days for the remaining 10 per cent. It suggested that the success was largely attributable to the complete integration of care planning across the acute and community interface (Northern HSC Trust 2008).

Difficulties with the integrated system

The inequality of health care and social care

In Northern Ireland there is broad agreement among health and social care professions that integration has not been a marriage of equal partners. The health agenda has dominated from the outset and this disparity persists. This situation has a number of fundamental implications. First, in the context of resource allocation, frequently priority

is given to the needs of health care, particularly acute health care, over those of social care. The total HSCB expenditure by programme of care for 2008/9 is given in Figure 5 (p 14): the programme of care for acute services dominates expenditure, with more than two-fifths of the total. Table 1, below, shows the per capita health and personal social services expenditure for Northern Ireland compared with that of England, Scotland and Wales. In 2010/11, health expenditure per capita was 10.8 per cent higher in Northern Ireland than in England, while personal social services expenditure was 5.1 per cent higher. Although health expenditure per capita in Northern Ireland was also higher than that in Scotland and Wales, the differential was smaller. Significantly, though, personal social services expenditure in Northern Ireland was appreciably less (O'Neill *et al* 2012).

Table 1 Government per capita expenditure on health and personal social services in Northern Ireland, Scotland, Wales and England, 2010/11

	Health (£)	Personal social services (£)	Health and personal social services (£)
Northern Ireland	2,106	512	2,618
Scotland	2,072	625	2,697
Wales	2,017	617	2,634
England	1,900	487	2,387

Source: O'Neill *et al* (2012)

Second, the medical model of need identification and response is highly influential. The integrated structure can easily be dominated by health agendas and priorities, such as the sustained focus on infection prevention and control. Performance targets set by the Department of Health relate almost entirely to health and include:

- outpatient waiting times
- inpatient and day care waiting times
- waiting times for diagnostic tests for cancer referrals
- beginning cancer treatment
- waiting times in accident and emergency (A&E) departments
- treatment in allied health profession areas
- first-year access targets for community mental health services.

Within the integrated system, social care values and priorities are overshadowed by a dominant health agenda, with social care relegated to the role of poor relation. The focus of public attention is on health. Adult social care failings and shortcomings do not have the same impact as hospital closures or stress on A&E departments. Significantly, the make-up of the executive teams of the HSC trusts reflects a health bias, with the majority of members from a health care background. In this context social care is afforded less priority and strategic influence. When compared with their health care counterparts, social care jobs tend to be poorly paid and have a low status, with few opportunities for progression.

All four of the UK countries are currently considering how they might best respond to growing and diversifying social care needs, but the Northern Ireland system is lagging behind, with community care policy operating under the vision and principles set out in *People First* (Department of Health, Social Services and Public Safety 2011a), which includes enabling individuals to remain in their own home or in suitable settings in the community. At the beginning of 2013, DHSSPS launched a consultation on social

care (Department of Health, Social Services and Public Safety 2013). The document noted that it was a difficult area which would have to be tackled, but offered no recommendations or options for the way forward. Interestingly, the document stated explicitly that it did not deal with health care, that is, treatments offered by professionals such as doctors, nurses and dentists.

A recent report from the Patient and Client Council supported the view that care should be provided as close to home as possible, with a shift in resources from hospital to community enabling this transition. There is support for the concept of ‘home as the hub of care’. However, the report suggested that it is evident that many people do not have full confidence in community-based services. Across a number of projects people have voiced concern about the quality, planning and delivery of community care, particularly for the most vulnerable in society. The *Care at Home* report into domiciliary care for older people (Patient and Client Council 2012) provides a good example of this dilemma: while most people said they would prefer to receive care at home where possible, many raised concerns about the inconsistent delivery and quality of home care. Age NI recently reported that evidence gathered through their discussions with older people suggested that the current model of social care is based on outdated ways of working, which results in poor value for money and does not always meet the outcomes that those in receipt of care expect (Age NI 2013).

Within social care there are some areas of work and services where integration is more prevalent. These include domiciliary services for the elderly, community services for mental health, learning disability and physical disability. This has led to integration being associated with these services and a reluctance to develop innovative approaches in other areas of social care where the benefits may be less obvious. Examples of areas where an integrated approach is less developed are direct payments, individual budgets, children’s services, and early-years child care and welfare advice.

Following the RPA and full integration of the hospitals into five HSC trusts, Heenan and Birrell (2009) suggested that any achievement of the promised potential of full structural integration in Northern Ireland would require:

- a higher profile for social care in the modernisation initiative
- a joint initial training session for health and social care professionals to reinforce a culture of integration
- a focus on outcomes for service users
- a renewed debate on social models of care
- the composition of the new bodies to reflect a more equal status between health and social care
- a systematic programme of research and evaluation in integrated working to provide a robust evidence base.

While health and social care professionals work alongside one another in Northern Ireland and often share a base, education and training systems are marked by separation. Despite the obvious synergies between the groups, current training systems offer few, if any, opportunities to interact with other related professions. Given the emphasis on multidisciplinary working and co-operation, this system is hardly conducive to shared understanding and can hinder joint working between health and social care staff. Professional stereotypes and issues of status are significant, and joint training and education could enable the different professional groups to understand one another’s roles, responsibilities and ways of working, and encourage mutual respect.

Case studies of good practice

While there is limited information and evaluation of integration in action, there is also a widespread recognition that there are many examples across Northern Ireland of innovative practice which aims to provide a seamless service of health and social care. The Southern HSC Trust, which covers the council areas of Armagh, Banbridge, Craigavon, Dungannon and South Tyrone, and Newry and Mourne – a population of some 358,650 – has been identified as an early innovator and an organisation committed to ensuring that their services are joined up and responsive. The reasons for this are manifold and may include leadership, vision and innovation, coupled with the absence of a dominant acute hospital.

Case study: Rapid access clinic in Lurgan Hospital

Within the Southern HSC Trust, Lurgan Hospital provides a consultant-led assessment clinic for rapid access for GP referral, and a community stroke rehabilitation service. The multidisciplinary team includes a consultant, an occupational therapist, a physiotherapist, a nurse and a social worker. Outcomes were audited for service users attending the clinic between 1 June 2010 and 27 May 2011. During the period, 300 people were seen; of these, 221 were discharged. The remaining 79 patients were admitted to hospital directly from the clinic. Thus for 74 per cent of service users, hospital admission was avoided on the day of the assessment. Of the discharged patients, just 8.6 per cent required an unscheduled admission via the A&E department. In 59 per cent of all service users, acute admission was completely avoided within 30 days. The facility provided a timely and comprehensive assessment of older people in a local setting and dramatically reduced the need for these older people to attend A&E.

The design of the service means that there is a single point of access for GPs and A&E. There is sharing of information and unified assessments, which are more cost-effective and efficient. Staff working in this team particularly valued its multidisciplinary nature and the fact that it was user-centred. The Director of Older People and Primary Care Services felt that this type of approach could ‘dissolve’ professional boundaries and ‘made sense at every level’. Feedback from service users and carers was described as overwhelmingly positive, as hospital admission was described as ‘traumatic’ for many older people. By providing accessible integrated health and care services within the community in facilities such as this, supported by multidisciplinary teams, an increasing number of people can be supported to live independently. This will, in turn, help to promote good health, improve management of long-term conditions, reduce unnecessary hospitalisation and length of stay in hospitals, and allow for early diagnosis and treatment.

Case study: Case management and pharmaceutical care of elderly patients in the intermediate care setting

Invest-to-save pharmaceutical care programme funding was provided by DHSSPS for service development in the provision of pharmaceutical care to older people in the intermediate/residential care setting. This funding was provided to the Western and Northern HSC Trusts in February 2012 for two years. The finance provided falls under the Regional Innovation in Medicines Management initiative, which aims to support and evaluate new ways of integrated working.

A consultant pharmacist in care of the elderly has been appointed at each trust to lead on this work, and two different models of care have now been implemented in the trusts. While the Northern HSC Trust has focused on medication review and case management

of nursing home patients (in collaboration with a consultant geriatrician), the Western HSC Trust has adopted a 'virtual hospital', intermediate-care case management approach within the Waterside Hospital. In May 2012, service provision was scoped and mapped out in order to determine exactly where integration of the consultant pharmacist into the multidisciplinary team would have the most impact on the seamless care of elderly patients.

The Western HSC Trust project was implemented May 2012 and will require assessment of the impact of the consultant pharmacist on the care of elderly patients who have been, or will be, admitted to the Waterside Hospital. The consultant pharmacist case manages from acute care, through intermediate care and back out into primary/community care, and is central to facilitating communication between health care professionals, including the consultant geriatrician, the GP and the community pharmacist. Clinical interventions made by the consultant pharmacist are being measured, independently assessed and costed. Outcomes of the study will include: length of stay on baseline admission; readmission rates within 30 and 90 days post-discharge; length of time to readmission; length of stay on readmission; medication appropriateness; and drug costs.

Data for the first six months is presently being gathered and explored for interim reporting (February 2013). To date, pharmaceutical care plans have been prepared for 260 patients, with a demonstrated improvement in appropriateness of prescribing (as measured by the Medication Appropriateness Index). Initial calculations yield potential annual drug cost savings of £85,000 per annum for patients staying on the three wards included in the project. Implementation of a new assessment of medicines adherence in intermediate care has projected annual savings of approximately £10,000 per annum. Potential involvement with nursing homes with high numbers of presentations at the A&E departments of hospitals within the Western HSC Trust is also being explored.

Case study: Patient flow throughout Altnagelvin acute hospital

In May 2010, the Western HSC Trust embarked on a programme of acute reform in Altnagelvin Hospital. Previous to this, patient flow through the hospital was not smooth and it was not uncommon to have numerous patients awaiting admission to the main hospital from the A&E department each morning, some of whom had waited in excess of 12 hours. This resulted in poor patient experience and patients were often allocated beds outside of their specialty which, evidence shows, increases their length of stay in hospital.

Each specialty operated within its own silo, and there was poor understanding or recognition of the need for a whole system approach to finding solutions to the hospital's problems. There was a clear belief by the team that inpatient beds were easily allocated if they became available. In order to achieve this cultural shift in practice, new ways of working were required which involved all members of the hospital and community multidisciplinary teams working towards a common goal.

The programme was called 'Back to the floor' and involved all senior managers and clinical medical leads walking the floors of the hospital at 8.30 each morning and challenging medical and nursing staff in relation to inpatients, delays in patients accessing diagnostics and other relevant services. The purpose of this was to ensure that patient flow became everyone's business, not just that of the bed managers.

The programme focused on three key areas:

- supporting and enhancing patient flow – this involves senior management and clinicians walking each ward every day to show support for ward-based staff as they tackle patient flow issues; this unique programme allows bottlenecks in the system to be exposed, and real-time and lasting solutions to be found

- early discharge – ensuring that admitted patients who are well enough to leave the hospital are discharged earlier in the day
- length of stay review programme – every patient in the hospital who has been in the hospital in excess of 14 days is reviewed by the community team in conjunction with the ward-based staff, and an action plan to facilitate discharge as soon as appropriate is agreed.

Since its inception, the reform programme in acute and older people's services and community care has been underpinned by a collaborative approach between senior doctors, nurses, nurse managers, community colleagues, the Performance Management and Service Improvement Directorate (part of the HSCB) and allied health professionals to focus on improving the patient experience in the hospital setting. This process is dynamic, can be changed as needed, and seeks solutions to problems in real time.

Colleagues were consulted at the outset of the programme to ensure broad scanning of all the service needs and those of service users. This programme has also been formally evaluated using both qualitative and quantitative approaches. The quantitative data looked at length of stay and delivered significant improvements, as outlined previously. The qualitative evaluations took the form of questionnaires, and thematic analysis demonstrated key themes aligned to improving the services. Some trust staff described the process as 'Perception that patient flow is everyone's work', 'Now trust-wide approach with trust-wide solutions and shared ownership', 'Enhanced communication and understanding across hospital and with community' and 'Now aware of each other's pressure and realise the need for whole system approach'.

Conclusions

Northern Ireland has had an integrated health and social care system for more than 40 years; however, for nearly three decades of direct rule the focus in this troubled region was on sustaining the delivery of services through the political and social unrest, rather than on policy innovation and future planning. Consequently, this integrated health and social care system has not realised its full potential and the opportunities provided by the structural organisation have not been fully exploited. Following the RPA, reorganisation in 2009 led to the creation of five fully integrated health and social care trusts covering primary, secondary and community care. This new, streamlined service was designed to produce economies of scale, simplify structures, reduce bureaucracy and promote further co-operation in order to maximise outcomes for service users. These new bodies are continuing to evolve and the extent to which they have met these aims is not yet evident.

A key issue in Northern Ireland is the lack of robust evidence to assess and evaluate the outcomes of this unique system. The effectiveness or otherwise of the integrated system is difficult to assess owing to the weakness of the existing data, which is particularly limited in terms of evidence of improved patient outcomes. To date, despite the fact that integration has been a key policy aim in the United Kingdom, no major study on the particular organisation of health and social care has been undertaken. The experience in Northern Ireland has usually been dismissed or overlooked, as Northern Ireland has its own peculiar context. Research in Scotland and Wales has highlighted the paucity of information from Northern Ireland and the difficulties associated with comparative study.

Despite this, a number of small-scale studies and policy overviews have identified key advantages and disadvantages of the system. Advantages include a single employing body, a single budget, and agreed strategies and plans on, for example, dementia care and mental health. Disadvantages include the continuing dominance of health care over social care, cultural differences between these areas, separate training systems, and GPs not being fully engaged in a whole system approach.

The Northern Ireland story demonstrates that structural integration can facilitate effective integrated working, but ultimately achieving a seamless service requires strong leadership underpinned by a clear vision, endorsed by the key stakeholders. There is no 'one size fits all' solution to meet the complex challenges but, as the case studies have shown, innovative local solutions can be found if senior staff share aspirations and space is given for innovative, creative ways of working.

The Transforming Your Care agenda, which aims to move care closer to home and tailor the care to the patients rather than deliver what suits clinicians, will increase the significance attached to social and community care. If this vision is to be realised, then it must be on the basis of equal weighting being afforded to both health and social care. Initial assessments of ICP membership and direction appear to suggest that, again, the focus is on herding GPs into further integration within the acute sector, with little consideration given to social care.

As this chapter has outlined, social care in Northern Ireland may need a package of extra support, including funding and legislation, to bring it up to a par with its health care partners. Shifting the focus of care provision away from acute hospitals towards a greater reliance on treating people in their own homes must be underpinned by a workforce development plan. Government must ensure that the social care workforce has access to relevant training and development opportunities, to ensure that individuals can be deployed in a range of roles. Improving the qualification base of the social care workforce is also a prerequisite to further professionalisation.

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2 Scotland

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Introduction

Closer integration of service planning and delivery is essential to ensure that service users can reliably access well co-ordinated, effective, safe and person-centred support and care that deliver value. This applies equally within the NHS, between primary, community and secondary care providers, and between health, social care, housing and other partners. Continuity and co-ordination of integrated care are of particular importance to frail older people and people with long-term conditions because the range and complexity of their needs require information, advice, support and care from multiple providers within health care and from other organisations across the statutory, independent and third sectors. This paper outlines the concerted efforts made in Scotland over the past decade to promote integrated care in order to improve the experience and outcomes for adults with long-term conditions and for their carers.

Context: the health and social care system

Political context

Scotland has a population of 5.2 million. Population density is low in comparison with the rest of the United Kingdom due to large remote and rural areas, notably in the Highlands. While the size of the population has remained relatively stable over the past 50 years, the proportion of people aged 65 and over has grown significantly and is projected to increase by around two-thirds over the next 20 years.

Following the passage of the Scotland Act 1998, the Scottish Parliament and the Scottish Executive (known as the Scottish Government since 2007) came into existence on 1 July 1999 and the powers relating to devolved matters were transferred to them from the Secretary of State for Scotland and other UK ministers. The Scottish Parliament has full legislative competence (ie, it can pass both primary and secondary legislation) across a wide range of devolved subjects. The Act lists the 'reserved matters' such as constitutional issues, foreign and defence policy, fiscal and monetary policy, and social security, for which the UK Parliament retains responsibility. Health and social care are devolved issues and represent the largest component of the budget that is provided as a block grant to Scotland by the UK Treasury (Keating 2010).

The Scottish Parliament has limited powers, to date unused, to vary the basic rate of income tax in Scotland by up to three percentage points. New powers set out in the Scotland Act 2012 to vary the rate by up to 10 percentage points will come into force in 2016.

Historical background

NHS Scotland

For much of the post-war period, the management, organisation and structure of the NHS in Scotland were broadly similar to elsewhere in the United Kingdom (Woods and Carter 2003). While there was some divergence in policy, there were limits on Scotland's autonomy (Hunter 1982; Keating and Midwinter 1983; Hunter and Wistow 1987). From 1974 until the early 1990s, 15 geographically based health boards had direct responsibility not only for hospital and community services but also for primary care contractor services within their areas. This differed from the arrangements in England, as did the absence of a regional tier of management.

In the early 1990s this model was replaced by one based on market principles, the so-called 'internal market'. Health boards became 'purchasers' of health care for their resident populations, and hospitals and community health services were established as separate NHS trusts which supplied services to the boards. Through fundholding arrangements, GPs could purchase a limited range of services from NHS trusts on behalf of their patients.

In 1997 broadly similar steps were taken across the United Kingdom to dismantle the internal market. From 2000, however, the NHS in Scotland has pursued an approach of increasing collaboration, partnership and integration, eschewing moves elsewhere to revert to a market in health care delivery. The unification of health boards and NHS trusts was completed by 2004.

The present government (in office since 2007) reaffirmed the commitment to a publicly provided service and announced a new focus on mutuality – involving patients, the public and NHS staff as 'owners' and partners rather than just users and providers – and on quality as a key organising principle for health care.

Local government

In 1996, local government on the mainland of Scotland was reorganised into 29 unitary authorities, replacing the regions and districts which had existed since 1975. The three existing island unitary authorities continued, making a total of 32 local authorities. As well as providing some services themselves, local authorities increasingly commission services from other providers such as the independent and third sectors.

The Local Government in Scotland Act 2003, designed to modernise local government, placed on local authorities a duty to secure best value and to initiate and facilitate community planning. In each local authority area a community planning partnership has been established to plan and oversee delivery of better public services and to co-ordinate other initiatives and partnerships. Led by local authorities, core community planning partners include the local NHS board, enterprise networks, police, fire and regional transport partnerships and other public, voluntary, community and private sector organisations.

Organisation of health and social care in Scotland

Scottish Government

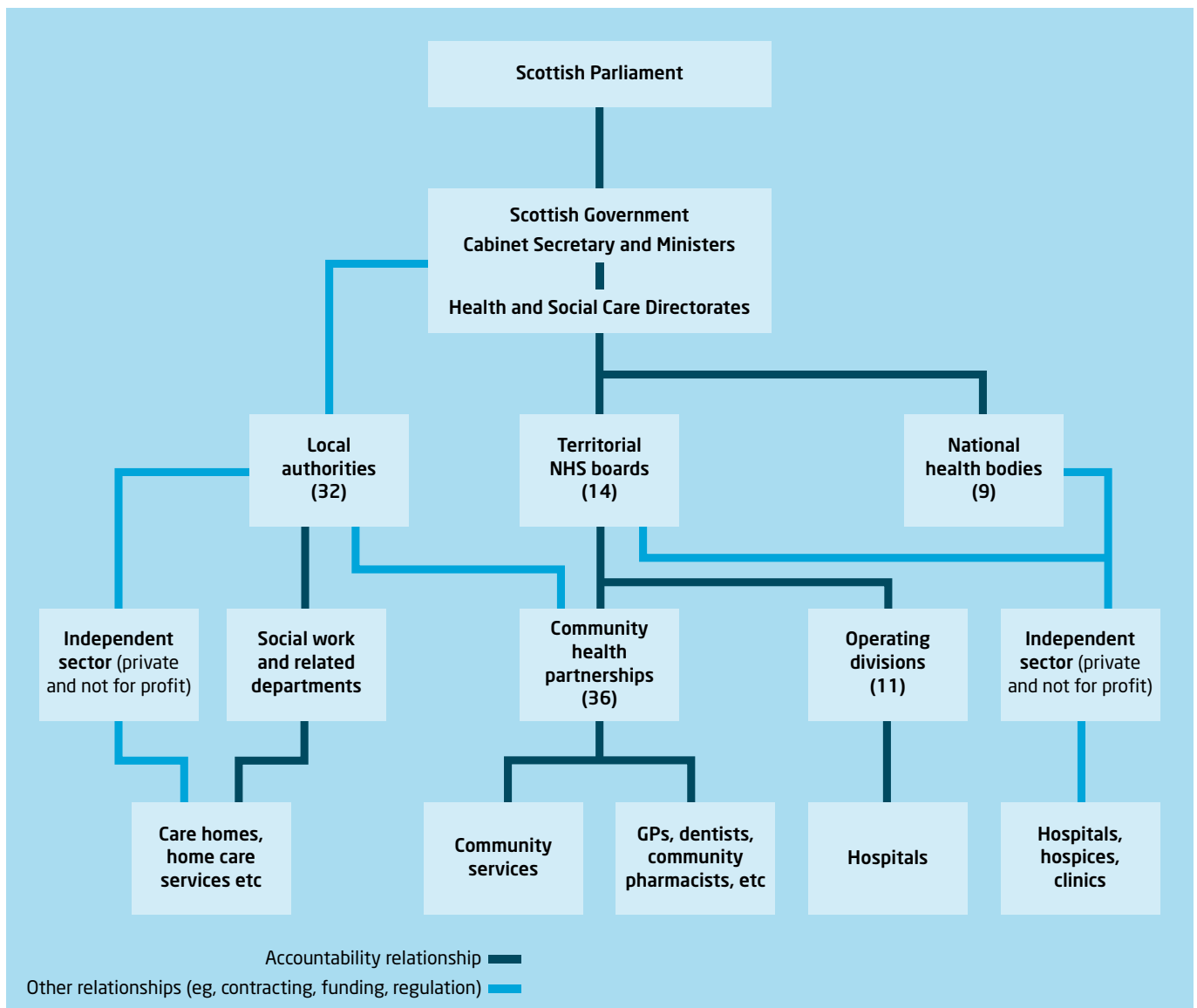
Responsibility for health and adult social care was combined in 2000 when the work of the former Social Work Services Group was divided at ministerial and official levels between health (adults) and education (children). Since 2007, responsibility for health and social care policy, the management of the NHS and oversight of adult social care

services has lain with the Cabinet Secretary for Health and Wellbeing (equivalent to the Secretary of State for Health in England) and the Scottish Government Health and Social Care Directorates, led by the Director-General for Health and Social Care, who is also Chief Executive of the NHS in Scotland.

A ministerial strategic group with responsibility to oversee health and social care reform is chaired by the Cabinet Secretary. It includes local government leaders, NHS board chairs and representatives from national, third and independent sector umbrella organisations. It is supported by a delivery group of officers chaired jointly by an NHS and a local authority chief executive and includes representatives from Scottish Government, the Convention of Scottish Local Authorities (COSLA), and the housing, third and independent sectors. Sub-groups on topics such as integrated resourcing, joint commissioning, outcomes, governance, improvement support and workforce report to the delivery group.

Figure 6, below, provides an overview of the structure of health and social care in 2011.

Figure 6 Health and social care system, Scotland



NHS Scotland

The key features of the health care system in Scotland are:

- integration of planning and delivery functions but with a high degree of operational delegation
- accountability of all parts of the NHS through NHS boards to the government and parliament
- co-operation and collaboration among all parts of the NHS and with other organisations
- partnership with staff and with patients and carers
- a focused performance management system designed to ensure that the NHS delivers its health improvement, health care and financial targets.

NHS boards

The majority of the health budget is provided to 14 geographically based NHS boards (reduced from 15 in 2006) which are responsible for planning and delivering services to meet the health care needs of their populations; these range on the mainland from 1.2 million (Greater Glasgow and Clyde) to 113,000 (Borders).

Each board comprises a non-executive chair, appointed by ministers after open competition, varying numbers (currently between 9 and 23) of non-executive directors (some lay members and others representing stakeholder interests such as the board's employees, the area clinical forum and each of the local authorities in the board's area), and normally around 6 executive directors. From 2010, a proportion of non-executive directors in two boards have been elected as a pilot to ascertain whether this improves public participation. An evaluation was published in 2012 (Greer *et al* 2012).

The focus of the boards is on strategic leadership and performance management of the entire local NHS system. Within each board responsibility for delivery is delegated to operating divisions for acute services and to community health partnerships (CHPs) for community and primary care services (discussed in more detail under 'Horizontal integration' on pages 34–36). Some boards have developed a model of a single operating system that combines both acute and community health functions.

In addition to the territorial boards, there are nine national bodies which are responsible, in partnership with the territorial boards, for services such as ambulance transport, education and training, and quality improvement, which are best provided on an all-Scotland basis. The composition and accountability of these bodies are broadly the same as for the territorial boards.

In 2011, the NHS workforce in Scotland comprised 161,369 people, of whom 154,340 (131,340 whole-time equivalents (WTE)) were employees of the NHS and the rest independent contractors (eg, general medical and general dental practitioners) providing services to the NHS.

Although not always co-terminous, NHS boards work closely with local authorities to ensure the effective delivery of a range of community health and social work services. This relationship is now formalised through representation of each local authority on the board of each relevant NHS board, through local authority membership of all CHPs and, in some cases, through joint accountability and joint appointments.

Local authorities

Since 1996 there have been 32 unitary local authorities with populations varying on the mainland from more than 600,000 (Glasgow City) to less than 51,000 (Clackmannanshire). Since 2007 councillors have been elected by single transferable vote, which ended one-party domination of most authorities.

In most respects the main features of the local government system in Scotland are broadly similar to those in the rest of the United Kingdom. Most operate through a structure of committees, with varying levels of delegated accountability.

Councils have a duty to provide social care for those who need it, whether they provide these services themselves, contract with voluntary or private organisations to provide them or give people a budget to arrange their own care. Increasingly, their role is to commission services from others, with councils themselves only providing around 12 per cent of care home places and 49 per cent of home care hours (Audit Scotland 2012).

Local authorities employed 244,500 (WTE) staff in 2010 of whom 41,100 worked in social work.

Independent (private) and third sectors

Scotland has a relatively small independent health sector, regulated from 2000 until 2011 by the Scottish Commission for the Regulation of Care (known as the Care Commission) and now by Healthcare Improvement Scotland. There are around 900 beds in 7 hospitals, 10 psychiatric hospitals and clinics and 15 hospices.

The independent health sector is funded mainly by voluntary health insurance or paid for directly by patients. The NHS contracts to a very limited extent with the independent sector for the provision of certain health care services. Hospices are charitable organisations and receive a substantial part of their funding from the NHS.

However, the independent and third sectors are important providers of care and support for older people, providing 88 per cent of care home places and 51 per cent of home care hours (Audit Scotland 2012), both registered with and regulated by the Care Inspectorate (which replaced the Care Commission in 2011).

Third sector organisations have always played a significant part in health and social care and continue to do so, frequently working in close partnership with statutory sectors to deliver services, funded by the NHS and local authorities and by charitable donations. They represent users of services, and lobby government on behalf of their members. Some are part of UK organisations, with varying degrees of autonomy, while others are separate Scottish organisations.

Funding

Public spending is mainly provided through the UK Treasury in the form of an overall block grant. In addition, funds are raised by local authorities by means of council tax and non-domestic rates; they also have borrowing powers.

Changes to the block grant are generally determined by the Barnett Formula, which is applied to all three devolved administrations. Under this formula, Scotland, Wales and Northern Ireland receive a population-based proportion of changes in planned spending on comparable services in England. Changes in each devolved administration's spending allocation are determined by the quantity of change in planned spending in departments

in England of the UK government, the extent to which the relevant English programme is comparable with the services carried out by each devolved administration, and each country's population proportion (HM Treasury 2010).

The Scottish Government therefore receives its formula share of any increase in resources provided to the Department of Health in London. However, the allocation of public spending among the various services it controls is for the Scottish Government to decide, subject to the approval of the Scottish Parliament.

The Scottish Government provided £11.68 billion for health in 2011/12, which made up 34 per cent of its total budget. After a decade of sustained and substantial growth (around 40 per cent in real terms), the health budget has been constrained since 2009. It has continued to grow in cash terms but has been decreasing in real terms. It is projected to increase by just over 5 per cent between 2011/12 and 2014/15, which amounts to a real-terms reduction of 2.8 per cent. Spending on health per capita in Scotland is significantly higher than in the other countries of the United Kingdom (in 2010/11 £2,072 in Scotland in comparison with £1,900 in England). This differential has narrowed in recent years from 16.5 per cent in 2006/7 to 9 per cent in 2010/11 (HM Treasury 2011).

Spending by local authorities in 2010/11 amounted to £18.5 billion, of which 80 per cent was funded by Scottish Government grant and 20 per cent by council tax and other sources such as rents and charges. Since 2007 there has been a freeze on council tax.

Local authorities spent around £3 billion on social care services in 2010/11. The total cost of social care is greater as this figure excludes the contributions people make to their own care by paying providers directly, expenditure from other council departments such as housing, and the money transferred from the NHS to support patients discharged from long-stay hospitals. Councils' spending on social care increased by 46 per cent in real terms between 2002/3 and 2010/11 (Audit Scotland 2012).

Looking forward, social care budgets are under pressure as a result not only of constraints on local authority spending generally but also the escalating costs of providing free personal care for older people, a policy introduced in 2002 only in Scotland (Scottish Government 2012d).

Creating the conditions for integrated care in Scotland

There have been a very large number of initiatives taken, some specifically targeted on integration, others with integration as a by-product of other developments, and some aimed either at health care alone or at the interface between health and social care, but many addressing both dimensions of the integration agenda. The focus of these initiatives has been on achieving better outcomes through partnership working, service redesign and the development of integrated clinical and care pathways.

The range of initiatives to promote integrated care in Scotland has been categorised in the following way:

- system (eg, unified boards, no purchaser–provider separation, clear and consistent accountabilities, duty to collaborate)
- community (eg, community planning, CHPs, shared budgets, single outcome agreements, elected boards, participation standard)
- clinical (eg, managed clinical networks, community resource hubs, team-based care, eHealth, collaboratives)

- financial (eg, unhypothecated budgets, independent budget allocation formula, shared services, managed service networks)
- culture and ethos (eg, clear and shared vision, mutuality, partnership, clinical leadership) (Feeley 2008).

These are all set within a policy landscape that has provided a coherent context to support the development of integrated care.

Coherent policy landscape

Achieving the twin aims of integration within health care and between health and social care has long been an objective of government in Scotland. Its importance has grown significantly since 1997 and has been a major feature of all the strategic documents that have been published on the structure and functioning of the NHS, underpinning both the creation of unified NHS boards integrating planning and delivery of services, and the development of collaborative and partnership working.

Integrated care was a particularly prominent aspect of *Building a Health Service Fit for the Future* (the Kerr Report) (Scottish Executive 2005a) and the subsequent government response *Delivering for Health*, which asserted that ‘Our objectives of high-quality services and better productivity will be achieved by promoting the integration of services’ (Scottish Executive 2005b).

In 2007, *Better Health, Better Care* reaffirmed the commitment to ‘strengthen the collaborative and integrated approach to service improvement that is the hallmark of Scotland’s NHS’ (Scottish Government 2007a). It stressed the importance of shifting the balance of care and made new commitments to introduce an integrated resource framework and strategic joint commissioning, and to strengthen the impact of managed clinical networks.

Integrated care is a key strand in *The Healthcare Quality Strategy for NHS Scotland* (Scottish Government 2010c). Within the context of Scotland’s integrated delivery arrangements, it encouraged whole system improvement through mutually beneficial partnerships between clinical teams and the people in their care and collaboration with other bodies.

Nor has the focus on integration been confined to the NHS. It was also a major theme in the report of the Commission on the Future Delivery of Public Services (the Christie Commission), published in 2011, which called for substantial reform of how public services are delivered to make them ‘outcome-focussed, integrated and collaborative’ (Scottish Government 2011c). One of its key requirements was that public sector organisations should work together effectively to achieve outcomes.

Since the report of the Joint Future Group, established in 2000 to improve structures and processes associated with joint working between health and social care (Scottish Executive 2000), there has been steady progress in establishing formal health and social care partnerships between NHS boards and local authorities. Legislation was enacted in 2002 (Community Care and Health (Scotland) Act) to break down some of the perceived barriers to collaboration by conferring powers to transfer specific functions, without removing statutory responsibilities, and the associated powers to create pooled budgets between health and social care partners.

Health and social care partnerships in Scotland are at different points on the continuum of integration described by the World Health Organization, which passes from autonomy

of individual organisations at one end, through linkage and co-ordination to full integration at the other. Arrangements have included:

- joint committees/planning forums
- shared performance management tools and reports to statutory bodies
- aligned budgets for community and social care
- joint appointments, in most cases managing joint funds as separate budgets for each partner
- some pooled budgets, generally for small stand-alone projects but in a few cases for services (eg, mental health services in Clackmannanshire)
- clinical and care networks that focus on pathway development (Scottish Government 2010a).

Aligned performance management

Delivering for Health (Scottish Executive 2005b) set out new arrangements for the management of performance in the NHS. This system has now been aligned to the National Performance Framework adopted by the Scottish Government in 2007 and replacing the proliferation of priorities that existed previously. Each part of this outcomes-based framework is directed towards a single overarching Purpose: ‘To focus government and public services on creating a more successful country, with opportunities for all of Scotland to flourish, through increasing economic sustainable growth’ (Scottish Government 2007b).

Five strategic objectives support delivery of the Purpose (a Scotland that is wealthier and fairer; healthier; safer and stronger; smarter; and greener) and, in turn, these are supported by 16 national outcomes which describe in more detail what the government wants to achieve over a 10-year period. Progress towards delivering these outcomes is measured through 50 national indicators and targets. A significant number of these outcomes and indicators relate to health and social care. The NHS was the first public service to report its performance through the *Scotland Performs* system and website (Scottish Government 2012j).

An important part of the Performance Framework is the Single Outcome Agreement (SOA) between the government and each community planning partnership (CPP). SOAs are the means by which CPPs agree the strategic priorities for their local area and express them as outcomes to be delivered by the partners, individually and jointly; these contribute to the national outcomes. A Statement of Ambition agreed in 2012 between the Government and COSLA places community planning at the heart of public service reform and sees it as a key means of driving the pace of integration and encouraging a focus on prevention, integration and improving performance (Scottish Government 2012c).

Quality improvement and scrutiny

The *Healthcare Quality Strategy* published in 2010 aims to ensure that all work is integrated and aligned to deliver the highest quality health care services to people in Scotland and in doing so provide recognised world-leading quality health care services (Scottish Government 2010c). At its core are three Quality Ambitions:

- mutually beneficial partnerships between patients, their families and those delivering health services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making

- no avoidable injury or harm to people from the health care that they receive, and an appropriate, clean and safe environment to be provided for the delivery of health care services at all times
- the most appropriate treatments, interventions, support and services to be provided at the right time to everyone who will benefit, and wasteful or harmful variation to be eradicated.

In 2011 the Cabinet Secretary set out a strategic vision and a supporting narrative for achieving sustainable quality in the delivery of health care services.

Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting. We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

(Scottish Government 2011a)

A Quality Measurement Framework provides a structure for understanding and aligning the wide range of measurement that goes on across the NHS, showing how it all leads towards the Quality Ambitions – which are illustrated by 12 quality outcome indicators. The three levels described by the framework are as follows:

- level 1 is for national reporting on long-term progress towards the Quality Ambitions
- level 2 contains the HEAT targets (*see below*), which are for shorter-term government performance management of NHS boards to implement key priorities
- level 3 is for all other measures required for quality improvement, either by national programmes or locally (Scottish Government 2010c).

NHS boards are required to produce annually a three-year Local Delivery Plan (LDP) which sets out specific actions, trajectories and risk management plans for achieving objectives and targets linked to the Scottish Government's overall Purpose and outcomes:

- Health improvement for the people of Scotland – improving life expectancy and healthy life expectancy
- Efficiency and governance improvements – continually improving the efficiency and effectiveness of the NHS
- Access to services – recognising patients' need for quicker and easier use of NHS services
- Treatment appropriate to individuals – ensuring that patients receive high-quality services which meet their needs.

LDPs and HEAT target performance are reviewed annually by the Scottish Government and the agreed LDP forms the annual 'performance contract' with the board.

Scrutiny and improvement

Unlike in England and Northern Ireland, responsibility for regulation and inspection of health and social care is divided between Healthcare Improvement Scotland (HIS), whose responsibilities since 2011 have included scrutiny and performance reporting on both the NHS and the independent health care sector (which it also regulates), and the

Care Inspectorate, which is responsible for regulation and inspection of social work, care and child protection services. The Care Inspectorate and HIS are testing a model for integrated inspections of services for older people, including those with dementia and who are residing at home or in a community setting.

HIS combines scrutiny with a strong focus on improvement support. In this respect its work is complemented by the Joint Improvement Team (JIT), established in 2004 to provide practical improvement support and additional capacity to local health, housing and social care partnerships. Itself a partnership between the Scottish Government, COSLA and the NHS, it has had a particular focus in recent years on the implementation of *Reshaping Care* and on the Change Fund (see 'Reshaping Care for Older People and the Change Fund' on pages 40–42), assets-based approaches and community capacity building, delayed discharge and intermediate care, joint commissioning and shared outcomes, and personalised outcomes-based approaches. The value of its work was endorsed by an independent review in 2011 (Petch 2011) and in the decision to establish a Joint Improvement Partnership Board, bringing together the JIT partners in a strategic partnership with the third and independent sectors. This arrangement will strengthen the position of the JIT, as the lead improvement partner in health, housing and care reform, to work with national partners to accelerate the pace of transformational change and to support and challenge improvement in the delivery of integrated health and care.

The only body with oversight of both health and social care services is Audit Scotland, which undertakes audit and value-for-money studies on behalf of the Auditor General for Scotland (health) and the Accounts Commission (local authority services including social work).

Horizontal integration

Both vertical and horizontal integration within health care have been taken forward since 1997 by progressive integration and unification of responsibility for hospital, primary care and community health alongside a range of specialist services for people with mental health problems, those with learning disabilities and older people.

Initially, voluntary combinations of GPs were encouraged to form local health care co-operatives (LHCCs), accountable to primary care trusts. From 2003 it was decided that LHCCs should evolve into community health partnerships (CHPs) to establish a substantive partnership with local authority services and to act as a focus for integrating health promotion, primary and specialist health services at a local level. The NHS Reform (Scotland) Act 2004 required boards to establish one or more CHPs in their area, albeit allowing differences in the size, role, function and governance arrangements for individual CHPs.

Broadly, two types of CHP evolved: health-only structures, known as CHPs, of which there were 29 in 2010; and integrated health and social care structures, known as community health and care partnerships (CHCPs) or community health and social care partnerships (CHSCPs), of which there were seven (the five integrated partnerships in Glasgow having been dissolved in 2010 and replaced by a single CHP for Glasgow). All are statutory committees or sub-committees of NHS boards and thus accountable to their respective board, although the integrated CHPs also have dual accountability to the relevant local authority (Audit Scotland 2011).

Membership of CHP committees was defined by the government and must include the CHP general manager, a GP, a nurse, a doctor who does not provide primary medical services, a councillor or an officer of the local authority, a staff representative, a member of the public partnership forum (which each CHP is required to establish to

maintain dialogue with the local community), a community pharmacist, an allied health professional, a dentist, an optometrist and a member of a health-related voluntary sector organisation. A number of CHPs have sought to strengthen local authority involvement by including elected members.

Two reviews of CHPs have been undertaken. The first, commissioned in 2009, found examples of progress in shifting the balance of care, for example, in the development of long-term conditions strategies and anticipatory care initiatives; in improving health, for example, in smoking cessation; and in building working relationships across the health family (although many had found engagement with GPs challenging). Linking health and social care had proved even more challenging, reflecting the changing context and complex environment in which CHPs operated (Watt *et al* 2010).

In 2011 Audit Scotland published their review of effectiveness of CHPs. While the report highlighted examples of good practice in developing enhanced community services, it found only limited evidence of widespread and sustained improvement. This was attributed to:

- CHPs not having the necessary authority to implement the challenging integration agenda that they faced
- a lack of clarity about the role of CHPs resulting from a ‘cluttered partnership landscape’ with CHPs having been added to already existing health and social care partnership arrangements
- differences in organisational cultures, planning and performance and financial management in the NHS and local authorities
- few examples of good joint planning underpinned by a comprehensive understanding of the shared resources available (Audit Scotland 2011).

Proposals to legislate for integrating adult health and social care

The Audit Scotland analysis was one factor contributing to the government’s decision to consult in 2012 on proposals to replace CHPs with health and social care partnerships (HSCPs) to secure greater integration between health and social care (Scottish Government 2012g). The proposals are based on four key principles.

- Health and social care services should be firmly integrated around the needs of individuals, their carers and other family members.
- There should be strong and consistent clinical and social care professional leadership in the planning and provision of services.
- The providers of services should be held to account jointly and effectively for delivering improved outcomes.
- Services should be underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve, rather than the organisations through which they are delivered.

The government’s response to the consultation, issued in February 2013, promised draft legislation by summer 2013 with the following key features.

- NHS boards and local authorities will be required to integrate health and social care services for all adults (with freedom to extend the integrated arrangements to other areas of service by local agreement and with provision for extension to be made mandatory in future).

- HSCPs, which may be established either as a body corporate in law or through a delegation between partners arrangement, will be the joint and equal responsibility of NHS boards and local authorities, and will work in close partnership with the third and independent sectors and with carer representation.
- Nationally agreed outcomes will apply across adult health and social care. HSCPs will be jointly accountable to their NHS board and local authority for the delivery of those outcomes. Outcome measures will focus initially on adults with multiple and complex support needs, including frail older people.
- HSCPs will be required to integrate budgets for joint strategic commissioning and delivery of services to support the national outcomes. Integrated budgets will include, as a minimum, expenditure on community health and adult social care services and, importantly, aspects of acute secondary care spend on adults.
- A single point of senior oversight and accountability, either a jointly accountable officer or the chief executive of the host partner (depending upon which model above is adopted), will ensure that partners' joint objectives, including nationally agreed outcomes, are delivered within the integrated budget.
- The role of clinicians, social care professionals and the third and independent sectors in locality planning and the strategic commissioning of services will be strengthened (Scottish Government 2013).

In advance of the proposed legislation, a 'lead agency' model has been adopted in Highland with NHS Highland as the lead agency for adult community care and Highland Council the lead agency for children's services. In both cases the lead agency is responsible for delivery of services and for management of staff and budgets. Both bodies retain joint responsibility for specifying the outcomes to be achieved for service users. These new arrangements, implemented in April 2012, involved the transfer of 1,500 social care staff and £90 million to NHS Highland, and around 250 staff and £8 million to Highland Council (NHS Highland 2012).

Vertical integration through managed clinical networks

Managed clinical networks have been an enduring feature of the health care system in Scotland for the last 15 years. They originate from the Acute Services Review of 1998 which advocated the evolution of informal networks into managed clinical networks (MCNs) which it defined as 'linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner, unconstrained by existing professional and health board boundaries' (Scottish Office 1998). They have been described as a vehicle 'to broker care across providers for patients with a particular condition in a form of virtual integration' (Curry and Ham 2010).

Since then the importance of MCNs has been highlighted in every statement of government policy for the NHS and the guidance relating to their development and functioning has been updated on four occasions, most recently in 2012 (Scottish Government 2012h). The key principles have remained consistent:

- clear management arrangements, including designation of a lead clinician (or lead officer in the case of multi-agency networks)
- a defined structure that sets out the points at which the service is to be delivered, and the connections between them
- an annual plan setting out, with the agreement of those with statutory responsibility for the delivery of services, the relevant standards and the intended quality

improvements and, where possible, quantifying the outcomes and benefits for users and carers

- use of a documented evidence base, which should be developed through continuous quality improvement (CQI) and audit, which MCNs should undertake, and research and development
- multidisciplinary and multi-professional composition with clarity about the role of each member of the MCN
- meaningful involvement of those for whom services are provided and the voluntary sector
- full use of educational and training potential including participation in appropriate appraisal systems and continuing professional development
- scrutiny of opportunities to achieve better value for money through delivery of care that adds value from the patient's perspective, optimises productivity and reduces unwanted variation.

There are currently around 130 MCNs in existence. They vary in their coverage: 29 are Scotland-wide, 22 regional, and the remainder local; and in their scope: some cover particular conditions such as diabetes or epilepsy; others specialties such as neurological disease or palliative care. There is a concentration in five areas where coverage is universal: coronary heart disease, stroke, diabetes and respiratory (all with MCNs in each board area), and cancer where there are three long-established regional cancer networks (personal communication 2013). National MCNs have generally been created in response to concern about access to and sustainability and quality of particular specialist services. A few MCNs (eg, mental health and learning disability) fully involve local authorities as well as the NHS as managed care networks.

There has been only limited evaluation of the impact of MCNs: one of the pioneer local cardiac MCN (Hamilton *et al* 2005); the other of four MCNs (two cardiac, two diabetes, in each case one voluntary, one mandated) (Guthrie *et al* 2010). Their findings identified a positive impact on inter-professional and inter-organisational activity, especially in MCNs that had been created as a result of local enthusiasm. This had resulted in some changes in professional practice and service improvement; it had also facilitated implementation of national initiatives, such as clinical guidelines. There was limited evidence of a beneficial impact in reducing emergency admissions to hospital. There has also been a review of nine national MCNs (National Services Division 2010).

The longevity of MCNs – unusual in health care – is an indicator of support for the concept in government and in the clinical and managerial communities. Although the existence of an MCN is only one of a number of contributory factors, it is striking that they are clustered in areas, such as coronary heart disease, stroke and cancer, in which there have been significant improvements in outcomes and quality of care in recent years.

In reaffirming the role of MCNs in 2012 the government asserted that:

- MCNs are ideally suited to delivering service redesign, quality improvement, strategy and planning across pathways, and working across boundaries of departments, teams, units, sectors, agencies and boards
- they have the potential both to inform and to help to deliver the kind of prioritisation needed to ensure value in a context of strict financial limitations, increasing patient demand and rising public expectations
- they need to adapt and align with other partnership structures that support partnership working with local authorities and the third sector (Scottish Government 2012h).

Information technology

In 2005 the Scottish Executive placed ‘increased sharing of information, with unified databases, effective communication links and standardised protocols’ at the heart of its drive to promote integration of services and initiated a process of developing a comprehensive health information system, based around an electronic health record (Scottish Executive 2005b).

Progress in this direction has been a key feature of the two eHealth strategies produced covering the periods 2008 to 2011 and 2011 to 2017 (Scottish Government 2008b; Scottish Government 2011b). Two important milestones have been achieved: universal use of the unique patient identifier, the community health index number; and the introduction of the national emergency care summary, accessible to NHS staff in out-of-hours centres, NHS24 and accident and emergency (A&E) departments.

Increasingly, communications between different parts of the NHS, for example on referrals, laboratory tests and prescriptions, are conveyed electronically. The current eHealth strategy also commits the NHS to developing, in partnership with local authorities, a health and social care IT strategy which will enhance information-sharing across health, social work and the third sector to support the delivery of appropriate community-based services.

Integrated Resource Framework

The Integrated Resource Framework (IRF) is being developed jointly by the Scottish Government, NHS Scotland and 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 (NHS Scotland 2012a). The IRF helps 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, and contributing to the development of the integrated budgets that will be required under the proposed legislation.

By providing 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 are able to realign their resources to support shifts in clinical and care activity within and across health and social care systems.

Central to the IRF is the 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. Most boards, some with their local authority partners, have completed a ‘first cut’ of their mapping and are currently working towards completing an improved ‘second cut’.

From April 2011 four test sites (Ayrshire and Arran, Highland, Lothian and Tayside NHS boards, and their 12 partner local authorities) have been engaged in implementing agreed and transparent financial mechanisms that will allow resources to flow between partners, following the patient to the care setting that delivers the best outcomes. The report of an action research evaluation of the work under way in the test sites was published in July 2012 (Ferguson *et al* 2012). It found that:

- mapping of cost and activity data across health and social care for the first time had improved the evidence base on equity, efficiency, variation and quality on which planning decisions are made

- the IRF had enabled senior managers in boards and local authorities to co-ordinate joint working and had empowered staff to reflect on how to work together to improve care pathways but, within the timescale of the evaluation, had not resulted in the release of resources or of significant changes in fixed costs
- the success of new ways of integrated working was linked to the extent of stakeholder engagement. Particular problems had been experienced in engaging GPs and hospital clinicians in discussion of the data
- whereas hospital data on cost and activity is centrally gathered and well developed, more work is needed on social care and community care data.

Looking to the future, the report concluded that successful integration requires clarity of purpose and outcomes, strong leadership commitment, empowerment of staff, patients and carers, agreement on an appropriate scale and scope, and alignment of all available drivers (policy, legislation, structures, information, incentives and outcomes).

Specific programmes to improve integrated care

Improving care for people with long-term conditions

Around 2 million people in Scotland have at least one long-term condition, and one in four adults over 16 report some form of long-term illness, health problem or disability. By the age of 75, nearly two-thirds of people will have developed a long-term condition. Recent research has also demonstrated that most people with a long-term condition have more than one and that the prevalence of multi-morbidity increases with age and is associated with deprivation (Barnett et al 2012).

Delivering for Health sought to introduce a systematic approach to managing long-term conditions (Scottish Executive 2005b). Its priorities were, first, to identify those people at greatest risk of hospital admission and provide them with earlier care to prevent the deterioration of their health; and second, to equip people at all levels to manage their own health, enabling them to take greater control of their condition and of their life. On the first priority, SPARRA (Scottish Patients at Risk of Readmission and Admission) was developed in 2006 to predict a patient's risk of being admitted to hospital as an emergency in a particular year. Initially restricted to those aged 65 and over, it was extended in 2008 to all ages, and further extended in 2012 to include primary care prescribing information in order to increase the predictive power of the algorithm (Information Services Division 2012).

Better Health, Better Care (Scottish Government 2007a) committed the government to producing a delivery plan for the next stage of work on long-term conditions and this was published in 2009 as *Improving the Health and Wellbeing of People with Long Term Conditions in Scotland: A national action plan* (Scottish Government 2009). It set out an approach to the management of long-term conditions based on the Wagner Chronic Care Model (Wagner 1998), adapted to reflect NHS Scotland's integrated structures, and its focus on quality improvement and on a mutual care approach.

A Long-Term Conditions Collaborative between 2008 and 2011 was tasked with supporting NHS boards and their partner agencies to deliver sustainable improvements in the management of long-term conditions through three workstreams on self-management, condition management and complex case/care management (NHS Scotland 2012b). It encouraged the use of a variety of service improvement tools and techniques, and developed resources such as high-impact changes, improvement action bundles, a community of practice and guidance notes on key change areas:

- GP practice/community team-based risk prediction coupled with targeted anticipatory care planning and case management
- intermediate care and pull-through to early supported discharge using specialist nurses and co-ordinated inreach by community teams
- telecare and telehealth for chronic obstructive pulmonary disease and cardiology allied with increasing use of cardiac and pulmonary rehabilitation
- system-wide managed clinical networks adopting generic approaches
- local commissioning development, and provision of self-management training, supported by web-based service information directories and a national Self Management Impact Fund. A strategy for self-management, 'Gaun Yersel', was developed by the Long Term Conditions Alliance, an umbrella organisation of third sector bodies (now known as the Health and Social Care Alliance) (LTCAS 2008).

Results to date show:

- a rising profile for co-production and asset-based approaches and evidence of the impact of the Self Management Impact Fund
- whole-system targeting of anticipatory support for high-risk/high-resource-use individuals
- use of Releasing Time to Care and Lean to free up community team time for direct care and improve working lives
- a 13.5 per cent reduction between 2006/7 and 2010/11 in the rate of emergency bed days for long-term conditions.

Reshaping Care for Older People and the Change Fund

Approximately £4.5 billion of public funding is spent each year on health and social care for those aged over 65 (Scottish Government 2010b). Well over half (60 per cent) of this is spent on care in hospitals and care homes (and almost one-third on emergency admissions to hospital). Less than 7 per cent is spent on home care. Overall, emergency admissions of older people absorb £1.4 billion each year (more than the total spend on social care for older people) and are expected to continue to grow unless action is taken. To address these demographic and funding pressures, changes are needed in the way in which care is planned and delivered.

Reshaping Care for Older People: A programme for change 2011–2021 sets out an ambitious plan, developed by the government, the NHS and COSLA, for reshaping care for older people across Scotland, along with the first set of key actions required to deliver it (Scottish Government 2010b). It sets out the vision of older people 'valued as an asset, their voices are heard and [they] are supported to enjoy full and positive lives in their own home or in a homely setting' and a national framework within which local partnerships are developing joint strategic commissioning plans. A new Change Fund has been established as a catalyst to reshape care between 2011 and 2015.

The Reshaping Care programme is being taken forward under the supervision of the ministerial strategic group and comprises a number of primary workstreams including future funding of long-term care; building capacity in the community and promoting a co-production approach; promoting active and healthy ageing and developing preventive and anticipatory care; providing proactive and integrated care and support at home; and considering the future role of the care home sector, housing and communities.

A multi-agency improvement network has been established to share learning; spread local improvements; increase the pace of change; and maximise the impact of the range of local and national improvement support available for Reshaping Care and health and social care integration. Led by the JIT in collaboration with a range of stakeholder organisations across all sectors, the network provides support to partnerships through:

- a programme of regular WebEx virtual meetings and national and local events
- regular e-bulletins
- evidence, resources and improvement tools on the website
- use of measurement for improvement
- collaborating across programmes and workstreams
- integrating outcomes-based approaches across a range of activities (Joint Improvement Team 2012b).

The Change Fund

A key element of the Reshaping Care programme is the Change Fund which is to be used as a catalyst to rebalance care, support and service provision towards anticipatory care and preventive services that support older people to stay in their own homes. It aims to encourage more innovative use of care home placements alongside improvements in care-at-home provision and housing-related support, and support for unpaid carers. A total of £70 million in 2011/12, £80 million in each of 2012/13 and 2013/14 and £70 million in 2014/15 has been allocated to the fund (Scottish Government 2011d).

The fund is distributed to each of the 32 partnerships by formula but is released only on receipt of plans prepared, agreed and signed off by the NHS board, local authority, and third and independent sector partners, and with evidence of engagement of carers and the public. Partnerships are required to provide evidence of how the resources have been used to:

- meet nationally available outcome measures and indicators such as emergency inpatient bed day rates for people aged 75 and over (an NHS HEAT target), delayed discharges, prevalence rates for diagnosis of dementia (NHS Quality and Outcomes Framework), and percentage of people aged 65 and over who live in housing rather than a care home or a hospital setting
- improve performance against the targets for user and carer experience in the Community Care Outcomes Framework (*see* page 45) such as the percentage of community care service users feeling safe, of users and carers satisfied with their involvement in the design of their care package, and of carers who feel supported and capable to continue in their role as a carer
- shift the balance of spending along the Reshaping Care pathway with increases in the proportion allocated to preventive and anticipatory care and proactive care and support at home. A couple of examples are provided in the boxes on p 42.

From 2012/13 onwards at least 20 per cent of Change Fund spending is to be dedicated to direct and indirect support to enable carers for older people to continue in their role.

The fund is a transitional source of bridging and partnerships are required to plan how they will use their collective resources to sustain the new mix of services, care and support before it closes in 2015. Change plans are a stepping stone towards the development of longer-term joint commissioning strategies. In recognition of the complexity of this task,

Hospital at Home in North Lanarkshire

Age Specialist Service Emergency Team (ASSET), an inter-disciplinary, multi-agency team (including allied health professions, community psychiatric nurses, social work, consultant geriatricians and nursing), offers an urgent response to prevent avoidable emergency admission and deliver safe, effective and person-centred care at home.

A GP responding to a patient in crisis calls the emergency response centre and is offered ASSET as an alternative to admission. The ASSET team responds within one hour and provides assessment, diagnosis and management of the acute episode and communication/referral to community health and social care teams to continue support at home.

Key results to date: around 80 per cent of patients seen are kept at home; mortality and readmission rates compare favourably with those who are hospitalised; and acceptability with patients and carers is high.

Source: Joint Improvement Team website

partnerships were given until February 2013 to produce the first iteration of such joint commissioning plans, again developed and signed off by the NHS, local authority, and independent and third sector partners.

The proportion of the Change Fund allocated to upstream preventive and anticipatory care rose from 19 per cent in 2011/12 to 23 per cent in 2012/13, and a continued shift in 2013/14 (28 per cent) and 2014/15 (29 per cent) is estimated where partnerships have provided this information. Overall, in 2012/13, partnerships are allocating 48 per cent of the Change Fund to preventive, anticipatory and more responsive community-based services aimed at supporting people at home and in their communities, with this estimated to shift to almost 60 per cent in 2014/15. Change Fund investment in hospitals and long-stay care homes will decrease from 23 per cent to 16 per cent with a corresponding increase from 24 per cent to 28 per cent of funding spent on community care and support at times of transition (Joint Improvement Team 2012c).

Commissioning for better outcomes in Midlothian

Change funding has been utilised to accelerate the process by which more effective and efficient services are commissioned. As a result: rapid response is preventing 18 emergency admissions a month; care home placements have fallen by over 20 per cent from the level predicted; the number of long-stay hospital beds has been reduced by 53 and the resources reinvested in community services; and average expenditure per head on older people increased between 2006 and 2010 by only 6 per cent (compared with 19 per cent and 21 per cent in two benchmark authorities).

Source: Joint Improvement Team website

Intermediate care

Intermediate care encompasses a range of functions that focus on prevention, rehabilitation, re-ablement and recovery at times of transition so as to prevent unnecessary hospital admission, delayed discharge from hospital and premature admission to long-term care.

Maximising Recovery and Promoting Independence: Intermediate care's contribution to Reshaping Care – an intermediate care framework for Scotland, published in 2012, describes a continuum of integrated services to prevent unnecessary admission to acute hospital or long-term residential care, promote faster recovery from illness, support timely discharge from hospital and optimise return to independent living (Scottish Government 2012i). Intermediate care services can be provided in:

- individuals' own homes, sheltered and very sheltered housing complexes
- designated beds in local authority or independent provider care homes
- designated beds in community hospitals.

Most Reshaping Care partnerships are using their Change Fund to develop or enhance intermediate care services. Some are aligning their local menu of services to create a single point of contact while others are developing rapid response and 'hospital at home' services.

Although emergency bed day rates for over-75s are declining across Scotland, the rates for emergency admissions of older people continue to rise, particularly for short-stay admissions of less than two days (*see* page 48). Pathways that provide rapid access to short-term hospital at home alternatives to admission will have high impact on acute care. Partnerships with comprehensive intermediate care services are showing accelerated reductions in rates of emergency bed days and delayed discharge compared with those that have been slower to implement hospital at home and other models of community-based intermediate care (*see* box below).

Re-ablement in Stirling

Change funding has been used to accelerate implementation of re-ablement. This has led to a 30 per cent reduction in home care needs and fewer long-term care beds being purchased as more people return home after a period of intermediate care delivered jointly by an integrated health and social care team. The proportion of people with intensive support needs living in housing rather than a care home or hospital setting has increased from 18 per cent to 35 per cent; spending on home care is unchanged and on care homes has reduced by 24 per cent.

Source: Joint Improvement Team website

In 2006 a strategy was published setting out a new role for community hospitals (of which there are 58 in Scotland, mainly in small towns in rural areas) as part of an extended primary care system, providing local access to a wide range of services, wherever possible on a 24/7 basis, and promoting a multidisciplinary, multi-sectoral approach to health care (Scottish Executive 2006). CHPs were encouraged to use existing community hospitals as a platform to provide a bridge between home and specialist hospital care, through ambulatory and/or inpatient services, not only in rural areas but also in larger towns and cities (*see* box overleaf).

Working together in Invergordon

The community hospital in Invergordon is used as a hub to integrate primary, community and secondary care. The inpatient beds are co-run by the GPs and the consultant with a joint GP/consultant weekly ward round and a multi-disciplinary team meeting including social workers, home care organisers, community nurses and allied health professionals which also discusses patients on the community teams' caseload. A small budget has been created to allow community teams to spot-purchase home care directly.

Source: Joint Improvement Team website

A *Community Hospitals Strategy Refresh* was issued in 2012 setting out the vision for community hospital development in the context of quality and integrated care and a network was established to drive improvement within and across boards (Scottish Government 2012b).

Self-directed support

To deliver the aim of social care being based around the citizen rather than the service, the Social Care (Self-directed) Support (Scotland) Act 2013 requires local authorities to give people a range of options for how their social care is delivered, beyond just direct payments, so that they can decide how much ongoing control and responsibility they want over their support arrangements. The Act also confers on local authorities a power to support unpaid carers and a duty to provide information to help people to make an informed choice.

Telehealth and telecare

Another development with significant potential impact on integration and in which Scotland is recognised by the European Commission as a leader has been telehealth and telecare. A Scottish Centre for Telehealth and Telecare was established in 2003 and is

Lochalsh and Skye Housing Association's Care and Repair Service

Lochalsh and Skye Housing Association's Care and Repair Service is working in partnership with NHS Highland and Highland Council to deliver telecare and telehealth monitoring devices cost-effectively to older people and people with disabilities in their homes. Telehealth devices are used to monitor long-term conditions such as chronic obstructive pulmonary disease, heart disease and certain mental health conditions. Daily test results are automatically sent to the Highland Hub Call Monitoring Centre, which generates an alert if any abnormality is identified. This increased monitoring reduces travel time for people in remote rural areas to and from hospital and leads to a corresponding reduction in stress levels. A demo/assessment room within Portree Hospital acts as a training facility for home carers, clients and community nurses to better understand the use and benefits of the devices.

Source: Scottish Government 2012a

now part of NHS24; the JIT has led a Telecare Development Programme since 2006; and initial strategies for telecare and telehealth were issued in 2008 and 2010 respectively (Scottish Government 2008c; NHS24 2010). In recognition of the potential of these technologies to contribute to the achievement of the Scottish Government's 2020 Strategic Vision (*see* page 33), a national delivery plan to 2015 for telehealth and telecare was issued in December 2012; one of its workstreams relates to the integration of health and adult social care, for example, helping people with long-term conditions to live independently at home by supporting them to manage their own health and care (Scottish Government 2012a). An example is provided on p 44.

Anticipatory care planning

Following evaluation of a successful pilot in Nairn (Baker *et al* 2012), NHS Highland introduced a locally enhanced service in 2009 to provide anticipatory care plans for adults identified as being at higher than average risk of hospital admission. These were defined as residents in older adult care homes and the highest 1 per cent risk group in the remaining practice population. Aims were enhancement of quality of care, providing care as close to home as possible and reducing occupied bed days. Practices were paid £75 per initial plan and £25 for each annually reviewed plan.

The cohort was matched with a control group with similar SPARRA scores. Overall increases in emergency admissions and bed days for the control were 51 per cent and 49 per cent respectively, compared with reductions of 38 per cent and 49 per cent respectively in the anticipatory care plan cohort (Joint Improvement Team 2012a).

The Scottish Government and the British Medical Association's (BMA's) Scottish GP Committee have reached agreement over changes to the General Medical Services contract for 2013/14 (Scottish Government 2012e). These include a commitment to introduce anticipatory care planning and polypharmacy review to replace quality and productivity indicators within the Quality and Outcomes Framework on A&E and emergency pathways. These changes, agreed with BMA Scotland (in contrast with possible imposition elsewhere in the UK), were heralded not only to 'help to reduce length of stay and emergency admissions to hospital but also give fresh impetus to integrated working'.

Lessons learned

Assessment of progress

Integration is not an end in itself but a means towards providing seamless care and support that is responsive to the needs and wishes of patients. This has been a key policy goal in Scotland for many years and earlier sections of this chapter have outlined various initiatives to promote its achievement. What effect have they had?

A national outcomes framework for community care was produced in 2008 comprising four national outcomes (improved health, improved wellbeing, improved social inclusion, and improved independence and responsibility) and 16 performance measures across six themes (user satisfaction, faster access, support for carers, quality of assessment and care planning, identifying those at risk, and moving services closer to users/patients) (Scottish Government 2008a). This is widely used by CHPs and their parent bodies for performance management (*see* box overleaf).

User and carer-defined outcomes have been developed through a Talking Points Personal Outcomes approach which comprises three types of outcome: quality of life; process (how services are delivered, how people feel they have been treated); and change (removal

Table 2 Talking Points User Outcomes, Scotland

Quality of life	Process	Change
Feeling safe	Listened to	Improved confidence
Having things to do	Having a say	Improved skills
Seeing people	Treated with respect	Improved mobility
Being as well as you can	Treated as an individual	Reduced symptoms
Living where you want/as you want	Being responded to	
Dealing with stigma/discrimination	Reliability	

Source: Joint Improvement Team (2012d)

of short-term barriers to quality of life) (see Table 2 above). There are also outcomes for unpaid carers which emphasise the importance of carers being treated as partners in decisions (Joint Improvement Team 2012d).

Some of the measures in the framework have become official targets. Prominent among these has been tackling two of the challenges that reflect fragmentation of service planning and provision: reducing the rate of bed days as a result of emergency admission of older people to hospital and speeding up the discharge of patients from hospital to an appropriate setting.

On the former, as Figure 7, opposite, shows, there has been a reduction in the rate of emergency bed days in acute specialties for people aged 75 and over by 7.6 per cent between 2009/10 (the year in which the Reshaping Care and Long-term Conditions Programmes started) and 2011/12, an estimated saving of around 550 beds in the number of beds required. From April 2012, there is a new HEAT target to reduce emergency bed day rates for those aged 75 and over by at least 12 per cent nationally between 2009/10 and 2014/15.

Looking at the broader 65 and over population, the overall change from 2009/10 is even greater (saving an estimated 750 beds). Figure 8, opposite, compares the level of actual admissions with that which would have been expected on the basis of demographic trends and an unchanged pattern of service provision.

Performance management reporting in East Renfrewshire

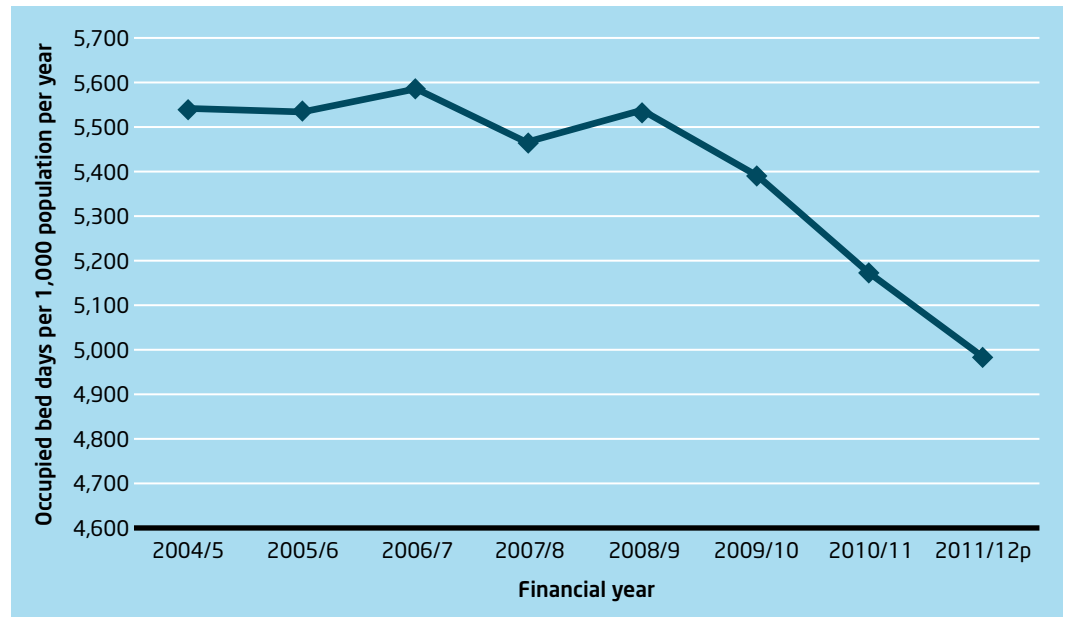
Performance is reported quarterly to the Community Health and Care Partnership (CHCP) Committee, using a traffic light system, on a wide range of measures:

- outcomes (19 measures including delayed discharges, hospital admission rates for long-term conditions, number of people receiving direct payments and percentage of home care clients receiving personal care payments)
- customer (10 measures including 7 drawn from Talking Points, mainly on quality of life issues)
- efficiency (6 measures relating to delivery of key assessments/services)
- people (10 measures mainly relating to staff absence and performance review).

The Talking Points Outcomes are woven into this process and have a major influence, for example, in the development of the Joint Commissioning Plan.

Source: East Renfrewshire CHCP (2012)

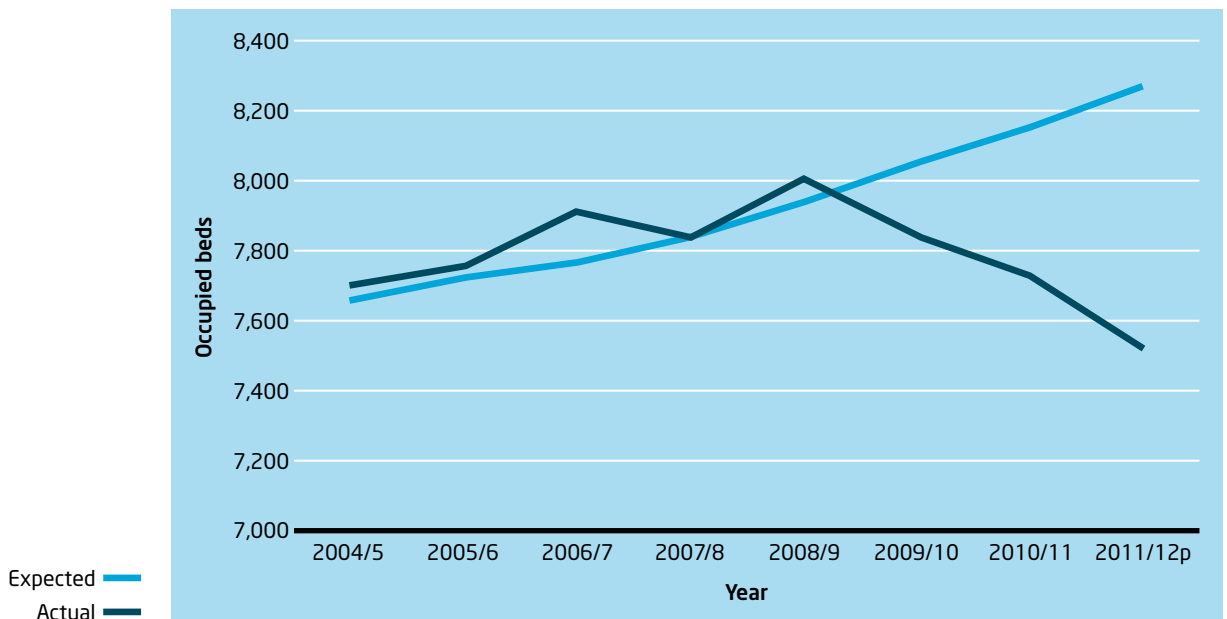
Figure 7 Rate of emergency bed days for patients aged 75+, Scotland



2011/12p: provisional

Source: Information Services Division Scotland (2013b)

Figure 8 Comparison of actual vs 'expected' trend in emergency bed use for patients aged 65+, 2007/8 rates, Scotland

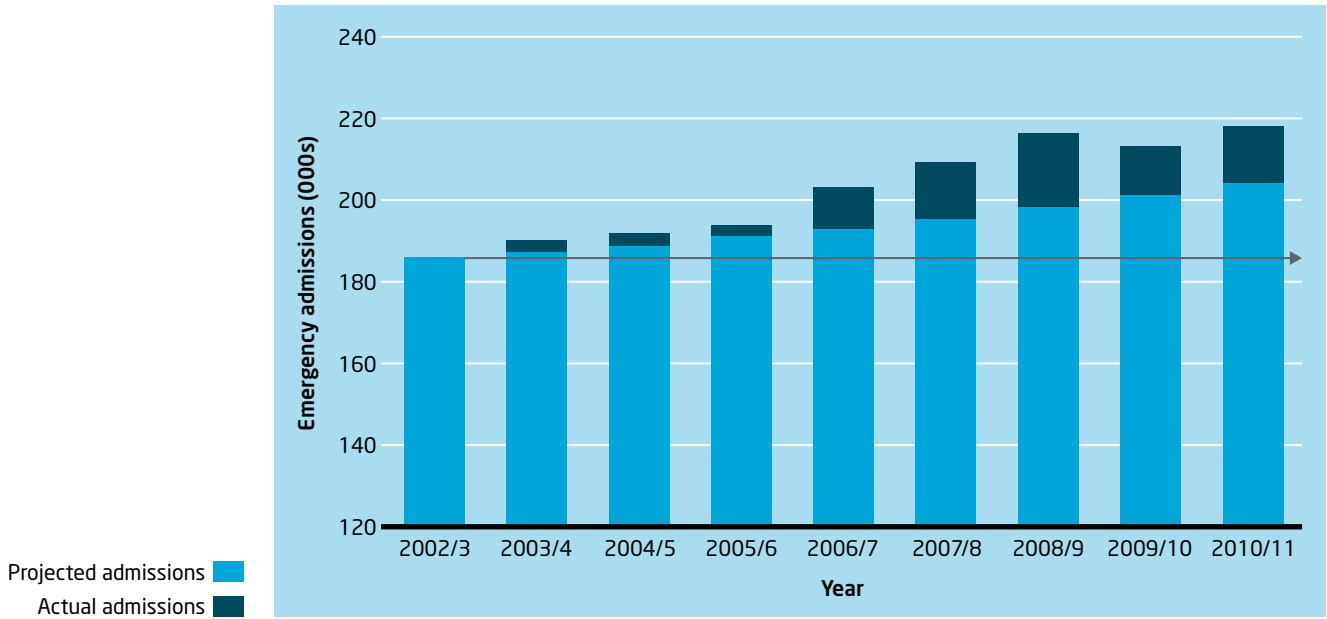


2011/12p: provisional

Source: Information Services Division Scotland (2013b). Analysis by Peter Knight, Lead on Partnership Information, Joint Improvement Team

However, challenges remain. As Figure 9, overleaf, demonstrates, the trend in the number of emergency admissions of people aged 65 and over continues to increase. The projected admission figures shown in the chart are estimated by multiplying the age-specific population size by the age-specific admission rates which applied in 2002/3. It shows that since 2002/3 actual admissions have risen faster than would be expected on the basis of the demographic changes occurring over this period.

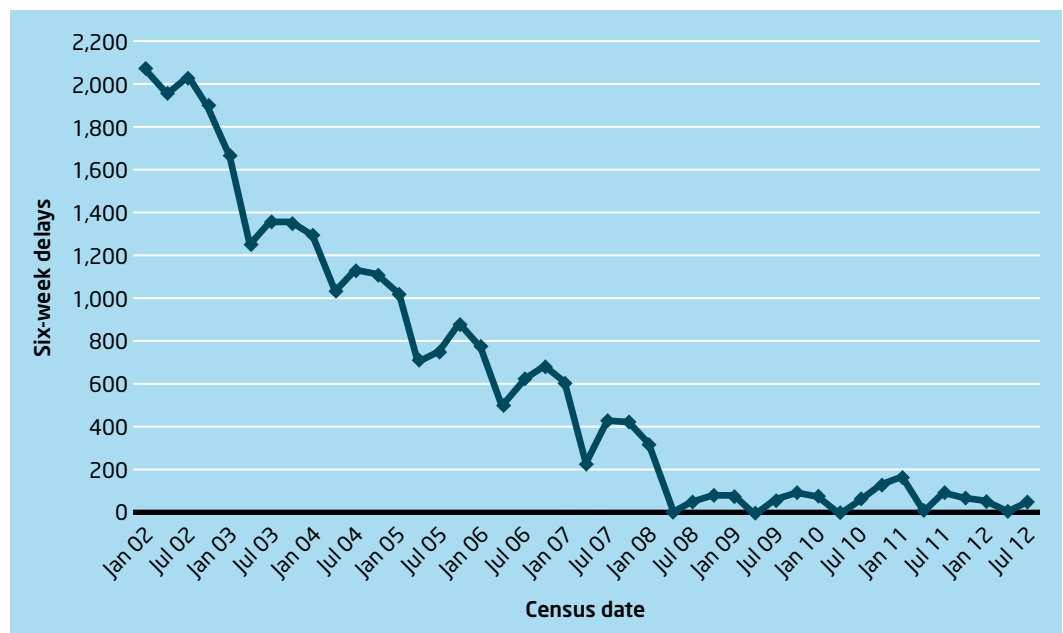
Figure 9 Hospital emergency admissions for patients aged 65+, actual vs projected numbers, Scotland



Source: Information Services Division Scotland (2013b). Analysis by Peter Knight, Lead on Partnership Information, Joint Improvement Team

On delayed discharge, there were more than 2,000 patient discharges delayed longer than six weeks in 2002; a target to reduce this number to zero by 2008 was achieved and subsequently numbers have generally remained below 100 (see Figure 10 below). However, delayed discharges still account for almost a quarter of a million bed days and cause considerable distress and anxiety. A new target was therefore set in October 2011 of reducing to zero the number of delayed discharges over four weeks by 2013 and over two weeks by 2015.

Figure 10 Levels of six-week delayed discharge, Scotland

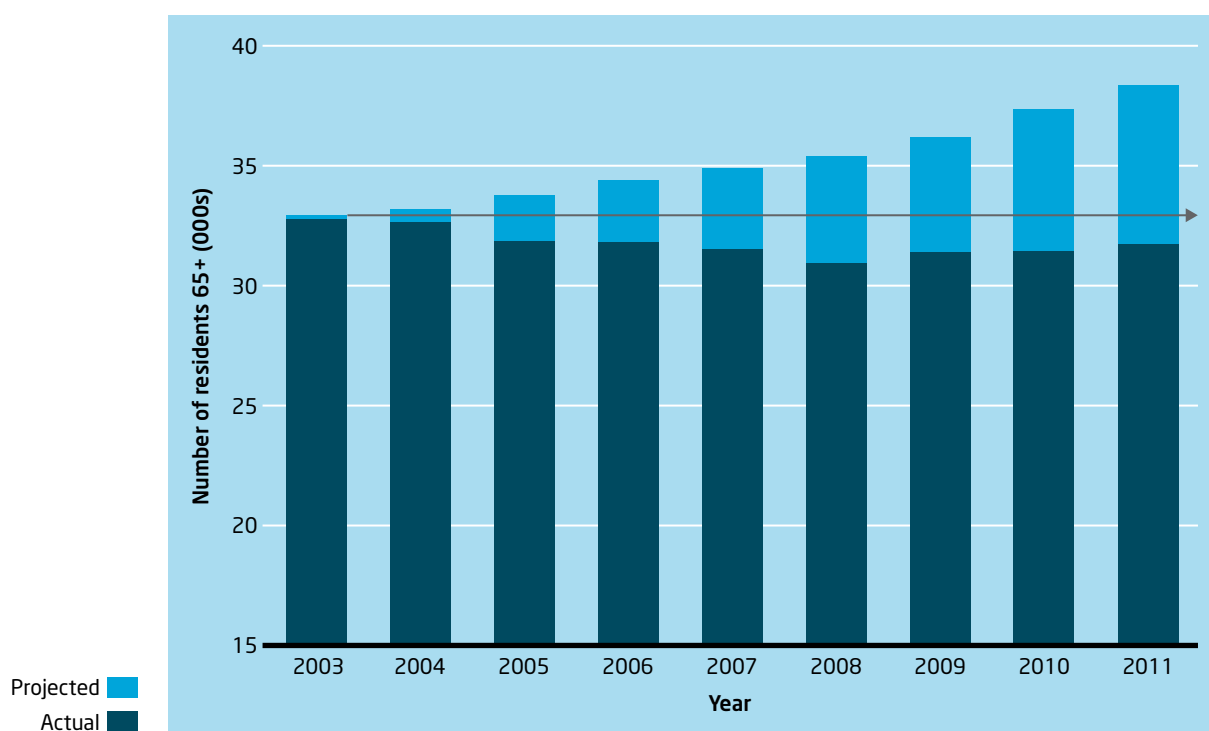


Source: Information Services Division Scotland (2013a)

The goal of shifting the balance of care for older people from institutional care to ‘home-based’ care can be tracked in two ways: by stemming the increase in the number of older people in care homes; and by increasing the number of those receiving intensive home care (defined as 10 or more hours a week).

In relation to the former, Figure 11, below, uses the same approach as in Figure 9 (see p 48) to compare the actual number of people aged 65 and over who are resident in care homes with projections based on demographic trends and an unchanged pattern of service provision, and shows that in 2011 there were around 6,500 fewer residents than the projection implies.

Figure 11 Long-stay care home residents aged 65+, actual vs projected numbers, Scotland

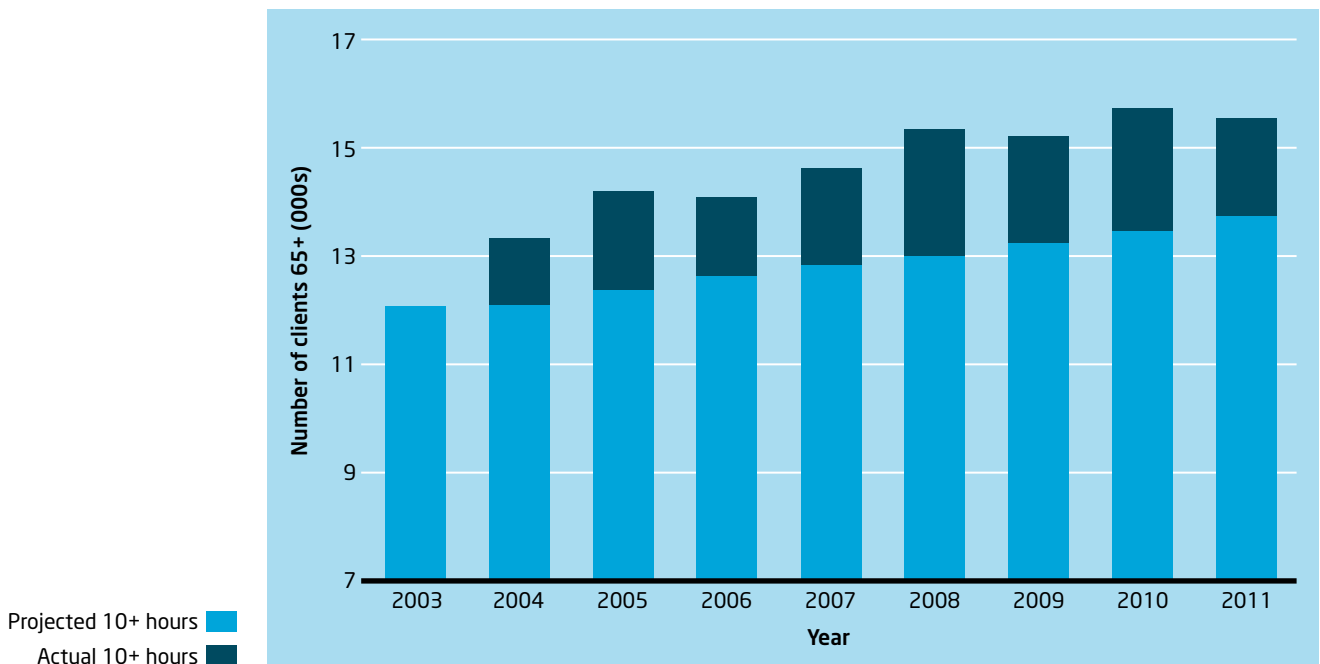


Source: Information Services Division Scotland (2013a). Analysis by Peter Knight, Lead on Partnership Information, Joint Improvement Team

Figure 12, overleaf, compares actual provision of intensive home care to people aged 65 and over with projections calculated on the same basis as in previous figures and shows that in each year more intensive home care has been provided than would have been expected on the basis of demographic change alone. By 2011 the difference between the actual and projected was about 1,800 people.

Sustaining any shift in the balance of care requires the transfer of resources from hospitals to primary care and community services and from the NHS to local authorities. CHPs were intended to have a key role in delivering such shifts in services and resources. As reported under ‘Creating the conditions for integrated care in Scotland’ (pp 30–39), work has been undertaken to obtain a clearer understanding of costs and activity across health and social care. However, Audit Scotland found in 2011 that there had only been a slight increase in the percentage of total NHS resources spent in the community between 2004/5 and 2009/10 and no change in the percentage of NHS resources transferred to local authorities during the same period (about £0.3 billion per annum or 3 per cent of the NHS budget) (Audit Scotland 2011).

Figure 12 Clients receiving intensive (10+ hours) home care, actual vs projected numbers, Scotland



Source: Scottish Government (2012f). Analysis by Peter Knight, Lead on Partnership Information, Joint Improvement Team

Enablers and barriers

This data provides evidence that, on the basis of what are widely regarded as output measures of integration, Scotland has in recent years made significant progress.

This reflects various factors that combine to make Scotland fertile territory in this respect. First, given that integrated service provision is not a quick fix but requires long-term sustained effort, its implementation has been facilitated by relative organisational stability, with no major structural change in the NHS for about 10 years and in local government for almost 17 years; and by political consensus, with all parties committed not only to integration but also to a partnership approach to achieving it. This has been bolstered by the strong personal commitment of successive ministers and leaders in the NHS and COSLA to the integration agenda and to an increasing focus across both the NHS and local authorities on implementation and improvement.

A second enabling factor has been the existence since 2004 of unified NHS boards, combining responsibility for planning and delivering acute, primary and community services and with strong local authority representation at board level and within each CHP to support better joint working between primary and secondary health care and between health and social care. This, coupled with the emphasis on collaboration rather than competition, has been of particular benefit for integration within the NHS.

Third, progress has been driven by a strong performance management culture within the NHS which since 2007 has been linked to the overarching national performance framework set by the government which also encompasses local government. This is underpinned by support and challenge for improvement across public services.

Fourth, Scotland's relatively small size – in this area as in many others – facilitates brokerage among the relatively small number of people occupying senior leadership positions in government, the NHS (both clinicians and managers), local government and the third and independent sectors.

Despite these enablers, significant barriers remain. Within the NHS, it has proved very difficult over the past 30 years to shift the balance of care. In the medical profession, acute specialties often have the loudest voice. Despite more than 30 years of promoting primary and community care, the public and even more the media still tend to equate the NHS with hospitals. Public pressure on politicians is also much more vociferous and sustained in relation to issues such as waiting times for elective procedures and access to new medicines. Public concern about the quality of care for older people or for people with mental health problems and learning disabilities hits the headlines from time to time but has not yet resulted in significant leverage on those responsible for decisions on the allocation of resources.

Even more intractable barriers stand in the way of achieving effective integration between health and social care. International evidence has identified three common and overlapping barriers:

- strong institutional and sectoral responsibilities expressed through vertical and organisationally discrete power structures
- funding streams, budgets and accountabilities remaining separate
- cultural, educational, professional and language differences and difficulties (Scottish Government 2010a).

These barriers apply in Scotland in spite of the enablers mentioned above. Despite the opportunities presented by unified NHS boards and by CHPs, there remain significant structural challenges resulting from what Audit Scotland described as a ‘cluttered partnership landscape’ (Audit Scotland 2011). The government’s latest proposals are designed to mitigate these differences in the governance arrangements and financial management procedures relating to health and social care. NHS boards and local authorities also operate in significantly different environments, with separation of commissioning and provision increasingly the norm in local government whereas it has been largely abandoned in the NHS.

There are also tensions surrounding joint working. At organisational level it has been necessary to build relationships (helped by local authority membership of NHS boards) between elected members of local authorities and their appointed counterparts on NHS boards. Local authorities have also been wary of acute dominance within the NHS; and on both sides (particularly the NHS) there has been concern about ‘losing control’ of resources allocated to them. Similar problems have arisen in relation to information-sharing where the potential benefits of IT – managerially and in patient care – have proved difficult to realise within either the NHS or local government, quite apart from across the interface between them.

There have also been a number of professional tensions compounded by public perceptions of the differing roles of health and social work professionals, seen, for example, in hesitancy over the sharing of records. Training, including continuing professional development, of key professions such as nursing and social work continues to be mainly separate. Effective joint working also challenges conventional hierarchies and reporting lines; and there are difficult issues to be overcome in harmonising terms and conditions of employment, including the ‘wicked issue’ of equal pay.

In its 2012 consultation paper on the integration of health and social care, the government acknowledged that, while there had been ‘very significant progress in improving pathways of care’, there remained ‘two disconnects in our system of health and social care’ (between primary and secondary care in the NHS and between health and social care) which make it difficult to address people’s needs holistically, and to ensure that resources follow patients’, service users’ and carers’ needs (Scottish Government 2012g).

Strikingly, the problems it highlighted as requiring to be addressed were unchanged from those in earlier statements of government policy:

- inconsistency in the quality of care for people, and the support provided to carers, across Scotland, particularly for older people
- unnecessary delays in discharge from hospital when patients are clinically ready for discharge
- services required to enable people to stay safely at home not always being available quickly enough, leading to avoidable and undesirable admissions to hospital.

Conclusions

Over the next decade, health and social care organisations will have to respond to the challenges of an ageing population, increasing numbers of people with complex long-term conditions, increasingly sophisticated (and expensive) treatments, and rising expectations of what health and social care services should deliver. None of these is new but they now have to be addressed in a climate of significant budgetary constraint. This makes it even more essential that different parts of the NHS develop new ways of working and that the NHS and local authorities work even closer together and with the independent and third sectors if they are to sustain and improve services that are person centred, effective and safe. This makes the sharing of learning from other countries, to which this paper is intended to contribute, all the more important.

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3 Wales

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Introduction

Wales constitutes about 8 per cent of the land mass of the United Kingdom, and is home to just under 5 per cent of its population – currently 3.1 million. As elsewhere in the United Kingdom, this is an ageing and expanding population, with numbers projected to increase to just over 3.3 million by 2033, including a 90 per cent increase in the number of people aged 80 and over. Overall, Wales is the poorest region of the United Kingdom, with a Gross Value Added (GVA) per head in 2010 of 74 (against an index where UK = 100). The largest sectors of the economy are public administration, defence, education and health (27.4 per cent of GVA, higher than the UK figure of 20.3 per cent) and production (19.5 per cent, compared with a UK figure of 13.7 per cent).

The health of people in Wales reflects its post-industrial economy. Life expectancy overall has increased in recent years, rising by 4.4 years for males and 3.0 years for females since 1991–3, reflecting a substantial decrease in deaths from circulatory disease in men under 75. But there remain substantial geographical and socio-economic variations in all types of life expectancy (Public Health Wales Observatory 2011). For example, healthy life expectancy in males ranges from 57.1 in Blaenau Gwent to 68.2 years in Monmouthshire, and for females the largest difference is around 10 years. National inequalities are particularly wide in healthy life expectancy. The gap between the most and least deprived areas is 18.9 years for males and 17.8 years for females.

Context: the health and social care systems

Political context

Wales was united with England in the 16th century, and the constitutional settlement changed little (beyond the creation of the post of Welsh Secretary in the UK Cabinet in the 1960s) until a referendum in 1997 paved the way for the Government of Wales Act and the formal devolution of certain powers in 1999 to a newly created National Assembly of Wales. These powers included most aspects of domestic governance, including health, local government, transportation, and economic and other planning. Its responsibilities are funded almost entirely by the UK parliament through a sum of money based on Wales' population share of the corresponding English expenditure, to be spent in Wales as determined by the Assembly. There are 60 elected representatives, known as Assembly Members, comprising constituency (40) and regional (20) Members, the latter allocated according to a formula which aims to ensure that the overall balance of the Assembly broadly reflects the number of votes cast for different parties. In addition, Wales is represented in the UK parliament by 40 Members.

The process of devolution continued with a subsequent Government of Wales Act (2006), which extended the powers of the Assembly to seek from the UK parliament legislative competence within 20 specified fields (including health and health services). This

competence would be granted for specific topics within the specified fields, a procedure now (following a referendum in 2011) replaced by a simpler approach, which allows the Assembly to legislate within its 20 fields without the prior approval of the UK parliament. The first Bills under this procedure are now in preparation.

There are up to 14 Welsh ministers who form the Cabinet and are accountable to the Assembly. The post-devolution governments in Wales have all been dominated by the Labour Party, either acting alone or in coalition with the Liberal Democrats or Plaid Cymru. The Labour Party currently governs alone, but with no overall majority. Given the electoral geography of Wales, it is likely that future governments will also be centre-left.

The Welsh Labour Party has followed quite different policies from its English counterpart, especially in health, and it rejects all notions of quasi-markets and competition in public services, seeking – in the words of its erstwhile leader and former First Minister, Rhodri Morgan – to create ‘clear red water’ between English (‘New’) Labour and Welsh Labour. In the NHS, this has resulted in very little engagement with private sector health providers, and a very cautious approach to the pharmaceutical industry. There is a determined attempt to get the various public services to work in partnership, using to the full the potential that comes from the fact that various public agencies, whether separately or as clusters, have common boundaries. Various mechanisms have been established to facilitate this, including local service boards (LSBs), which, led by local authorities, bring together local agencies in partnership to tackle issues that need a common approach.

The recent history of health and social care

Pre-devolution, health and social care policy in Wales closely followed that in England. Some small differences emerged over time, but these were confined to minor adaptations of policy to fit the particular circumstances of Wales (such as adjustments to the resource allocation formulae), or to small-scale initiatives which did not call into question national policy, such as the development of non-acute treatment centres in the 1980s, or the pioneering development of various public health initiatives in the 1980s and 1990s. Wales’ adoption of the internal market was not as enthusiastic as that of England, even before devolution – GP fundholding did not achieve the same level of penetration as in England, for example – but the policy aims in key government priority areas were indistinguishable from those in Wales’ eastern neighbour.

One area where policy implementation in Wales did diverge somewhat from that in England was in relation to local government reorganisation in the mid-1990s. The result across the whole of Wales was the replacement of the two-tier structure with 22, relatively small, unitary authorities, responsible for all local government services. They include just three with a population of more than 200,000, and seven with a population of fewer than 100,000. The intention was to simplify responsibilities and devolve accountability to smaller populations. The architects of this change hoped that authorities would choose to collaborate in the provision of services, appointing joint directors. But – perhaps not surprisingly – this did not happen, and Wales still has a relatively large number of small local government services, with the attendant difficulties in ensuring critical mass and avoiding inefficiency.

Since the devolution of powers in 1999, the gap between health and social care policy in Wales and England has steadily widened. Policy has been dominated by a desire to move Wales away from the quasi-market approach in England, reasserting an approach that prioritises public health and tackling health inequalities, and insists on the benefits of collaboration between public services – and especially the NHS and local government – in

joint efforts to improve well-being and to deliver seamless services which place the citizen at their heart.

As a result, Wales followed the abolition of GP fundholding with the creation of local health boards (LHBs) that were co-terminous with their local authority partners. LHBs commissioned services from more than a dozen NHS trusts; but, with no national tariff and little encouragement for competition between providers, this was little more than an echo of the internal market. Until 2009, the emphasis on partnership working meant that Wales had to have 22 LHBs to match the 22 local authorities. This was increasingly recognised as untenable, as the difficulties in equipping the (often very small) LHBs to effect the major strategic shifts required of them defeated any attempts to do so. The analysis of the responses to the Welsh Government consultation on reorganisation suggested that many felt that the LHBs made good progress in establishing collaborative relationships with their local authority partners, and often enjoyed strong relationships with primary care, but their ability to engage effectively with the much larger trusts – which often served several LHBs – in order to increase their productivity and bring services into the community, was disappointing.

A further reorganisation of NHS services had therefore become inevitable, and the formal merger of the commissioning and providing functions into seven new LHBs was described by the Welsh Government as the removal of the final vestiges of the internal market. Local government reorganisation has also been mooted on several occasions, but the political opposition has so far been too strong.

Organisation of health and social care in Wales

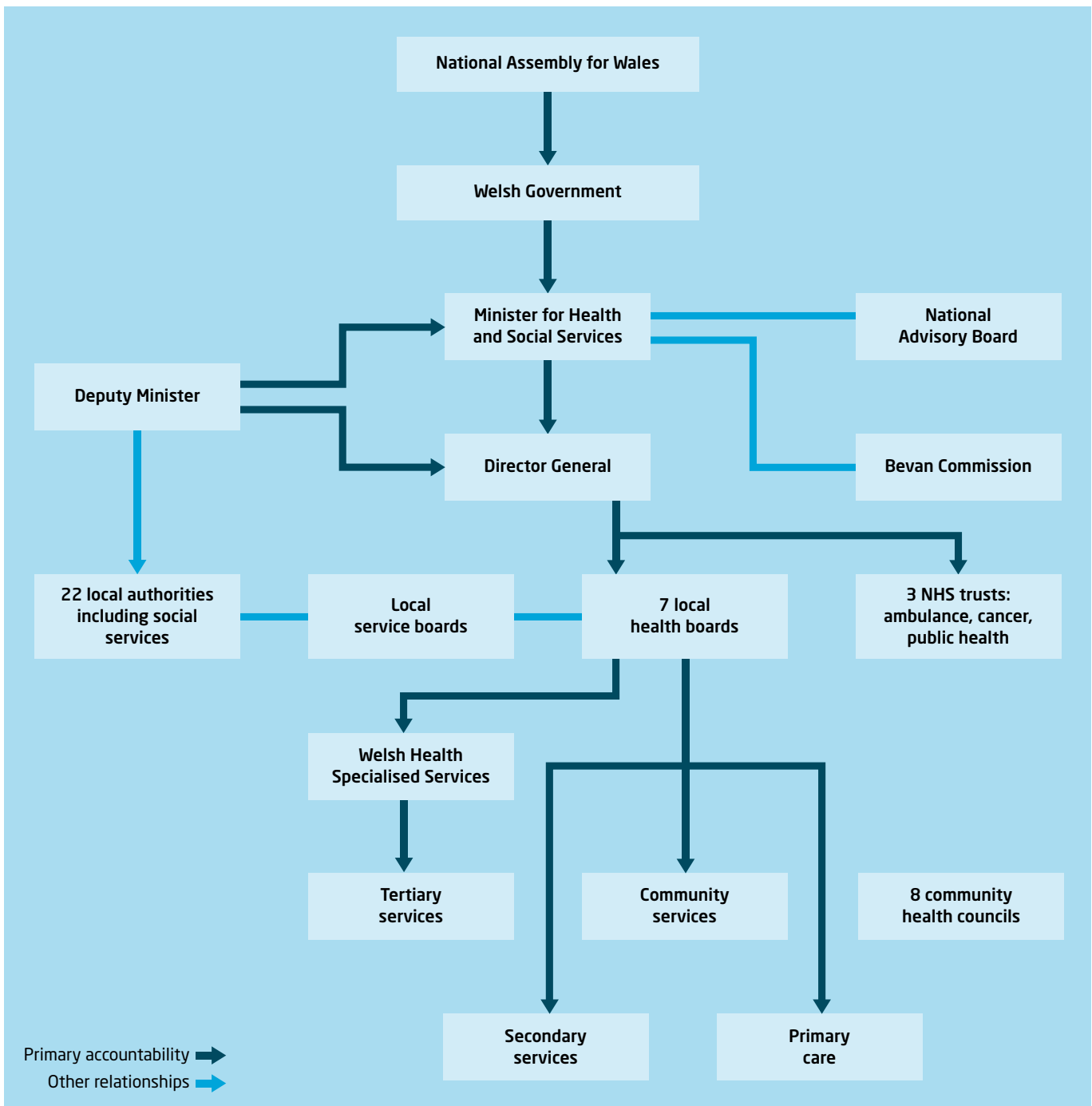
The post-2009 structure of the NHS in Wales unifies the planning and delivery functions of primary, secondary and tertiary care on a geographical basis, in seven LHBs: there is no purchaser–provider split. In addition, there are three NHS trusts – for the Welsh Ambulance Service, for public health and for specialist cancer services (the Velindre NHS Trust). Specialist care is now commissioned by the Welsh Health Specialised Services Committee, which is accountable to the seven LHBs. Public and patient input is the statutory responsibility of eight community health councils, the successors of the bodies originally established in 1974. Figure 13, overleaf, shows how the structure is organised.

The Minister for Health and Social Services is supported by the Department for Health and Social Services, the Director General of which is also the Chief Executive of the NHS in Wales. The Deputy Minister takes the lead on policy matters relating to social services and social care, the delivery of which remain largely a responsibility of local government.

The Welsh Government sets the framework for health and social care through national policy and strategy documents. The major strategic documents are *Our Healthy Future* (Welsh Assembly Government 2009b), *Together for Health* (Welsh Assembly Government 2011b) and *Sustainable Social Services for Wales: A framework for action* (Welsh Assembly Government 2011a). In addition, the Welsh Government sets out annual requirements in relation to NHS performance. The responsibility for local planning lies with the LHBs. They plan all services for their own resident population and work together through the Welsh Health Specialised Services Committee to make available national and highly specialised services for the whole of Wales. Those services include, for example, ambulance services, and highly specialised cancer and mental health services.

LHBs are also required to work with other public services locally through joint LSBs, whose role is to co-ordinate action in those priority areas where co-operation is most needed and can be expected to yield greatest results, and to produce integrated plans

Figure 13 The organisation of health and social care, Wales



for each local authority area. LSBs are not statutory bodies, but rather ‘an expression of engaged public service leadership locally’ (Welsh Government 2012b, p 7). Their role is to:

- agree the strategic priorities for multi-agency working
- ensure that arrangements are in place to deliver joint working as appropriate
- challenge local underperformance
- review and report progress annually.

Their core membership consists of the local authority (political and/or executive), police, health service, third sector parties and a senior representative of Welsh Government (the last, in part, to relay messages to central government about the changes required in their own ways of working).

To rebalance health services and develop more services closer to home, primary and community health care is being planned through approximately 60 locality networks, made up of clusters of GP practices working in partnership with other providers such as pharmacists.

The responsibility for standard setting, monitoring and enforcement is divided between several bodies, with professional regulation of the health care professions (although not of social workers) being vested in UK or British bodies. Table 3, below, shows this in more detail.

Table 3 Allocation of responsibility for health and social care, Wales

Function	Regulatory institution
Standard setting	Welsh Government – The Welsh Government issues health care standards. Clinical elements of the standards are underpinned by National Institute for Health and Care Excellence (NICE) guidance and by standards issued by professional bodies such as the General Medical Council .
Monitoring	Healthcare Inspectorate Wales (HIW) – HIW is the independent inspectorate and regulator of health care in Wales. The Care and Social Services Inspectorate Wales (CSSIW) has equivalent responsibilities for social care, and Estyn covers education and training. Wales Audit Office (WAO) – WAO is the public service watchdog for Wales. Bodies in England, such as the Healthcare Quality Improvement Partnership , NHS England and the Health Research Authority, also currently assist Wales in monitoring health care.
Enforcement	HIW and CSSIW – HIW will undertake special reviews and investigations where there appear to be systemic failures in delivering health care services. WAO audits the accounts of public bodies and publishes audit reports. If necessary, WAO will publish a 'Report in the Public Interest'. Professional bodies, such as the General Medical Council , also assist Wales in the enforcement of standards, and they may take action against members to protect patients from harm.

Wales currently has more than 120 hospitals as part of an overall estate valued at £2.3 billion. These include:

- 13 hospitals with major accident and emergency (A&E) units (approximately 2 per LHB area), and a wide variety of acute medical and surgical specialties. Two hospitals (Swansea and Cardiff) also provide specialist tertiary services for the south of Wales
- 15 hospitals with minor A&E units or minor injuries units
- 46 community hospitals (with the highest numbers in rural areas in north, central and west Wales), providing a mixture of rehabilitation, step-down and GP beds.

The NHS currently has approximately 72,000 directly employed full-time equivalent staff, reflecting an increase of almost a quarter in the first decade of the 21st century. Table 4, overleaf, gives a breakdown of this figure into staff groups.

In 2011, there were 2,022 GPs working in 483 GP practices in the NHS in Wales, of whom 43 per cent were women. Some 13 per cent of GPs work in single-handed practices, although they may employ a salaried GP or a GP trainee. The list size has fallen in Wales by 6 per cent (from 1,665 to 1,564) between 2001 and 2011 (6.5 GPs per 10,000 registered patients).

A new Mental Health Strategy for Wales is now in development and will cover the whole life course services for children, adolescents and older people. It aims to consolidate existing policy and address mental health and well-being as well as mental health problems, challenge stigma and discrimination, focus on the individual's care within a

Table 4 Breakdown of NHS staff numbers (full-time equivalent), Wales

Staff group	2001	2011	Percentage change in the last	
			10 years	1 year
Medical and dental	3,907	5,813	+48.8	+2.8
Nursing, midwifery and health visiting	24,751	27,999	+13.1	-0.6
Administration and estates	12,326	15,230	+23.6	-1.8
<i>of which: managers</i>	1,339	2,092	+56.2	-10.7
Scientific, therapeutic and technical	7,605	11,450	+50.6	-0.3
Health care assistants and other support	7,781	9,711	+24.8	-3.4
Ambulance	1,103	1,458	+32.2	+2.1
Other	121	157	+29.7	-0.9
TOTAL	57,595	71,817	+24.7	-0.9

Source: Statistics for Wales (2012)

recovery approach, and embed the Mental Health (Wales) Measure 2010. This Measure, a piece of law made by the National Assembly for Wales which has a similar effect to an Act of Parliament, makes several important changes to the current legislative arrangements in respect of the assessment and treatment of people with mental health problems in Wales, and is intended to expand primary care mental health services and the duties relating to the provision of statutory advocacy.

Performance management

All NHS bodies in Wales are accountable to the Welsh Government for their performance against government objectives and priorities. Local government accountability is more complex, being primarily to the local electorate, but with government having monitoring and other roles. Strategic health priorities (Welsh Assembly Government 2011b) currently include:

- service modernisation, including more care provided closer to home and specialist ‘centres of excellence’
- addressing health inequalities
- better IT systems and an information strategy ensuring improved care for patients
- improving quality of care
- workforce development
- instigating a ‘compact with the public’
- a changed financial regime to allow greater clinical involvement in financial decision-making.

Monitoring of health bodies’ performance is set against a series of Tier 1 and Tier 2 targets. The former are ‘key priorities where immediate improvement is necessary or where performance at defined target levels must be sustained’ (NHS Wales 2012, p 1), and include 11 areas such as quality, mortality, access, and efficiency and productivity. The monitoring regime becomes progressively more intense as performance deviates from the specified level. Tier 2 targets are either longer term or subject to local monitoring, and include prevention and health promotion, primary care and clinical leadership. Both tiers are a mixture of nationally specified requirements (for example, on access or efficiency), those where LHBs are required to develop their own performance targets (such as for mortality rates) and those where the local partnership will agree targets (such as on child poverty or health promotion).

Funding

Overall expenditure on health services in Wales increased over the first decade of the 21st century broadly in line with that elsewhere in the United Kingdom (National Audit Office 2012). In 2010/11, spending per capita in Wales on health was £2,017, compared with £1,900 in England. Comparisons are often made between Wales and north-east England, the region most similar demographically to Wales: spending in that English region per capita was £2,091 in the same year. The NHS in Wales now faces a period of financial retrenchment greater than that elsewhere in the United Kingdom, as a consequence of the decision by the Welsh Government not to afford the same degree of protection to health spending as that granted elsewhere.

Wales has relatively little private financing of health care, and very little use is made of the private sector by the NHS. Budgets are allocated to the seven LHBs (three have allocations in excess of £1 billion a year); GPs and other private contractors are remunerated in similar ways to those elsewhere in the United Kingdom. Limited use is made of formal mechanisms to pool funding between NHS and other public bodies. Use of cost-sharing mechanisms was reduced when the Welsh Government was, in 2004, the first in the United Kingdom to announce its intention to abolish patients' contributions towards the cost of prescriptions; more recently the government has ended charges for parking on hospital premises (except where existing contractual arrangements preclude this).

Net expenditure on social services in Wales in 2011/12 was £1.4 billion, with services being delivered to more than 70,000 people. Some 24,700 people were directly employed by social services, with care being provided in 1,800 regulated care settings and more than 12 million hours of care being provided to older people each year (Welsh Government 2012c).

Funding for local government in Wales has been protected to a greater extent than in England (Crawford *et al* 2012). For example, between 2009/10 and 2012/13, local government expenditure in England (excluding education) decreased by 15.6 per cent, compared with 9.3 per cent over the same period in Wales. For social services, these reductions have taken away about £1 in every £8 gained between 2001/2 and 2009/10. During the past three years, expenditure on social services has decreased by 11.8 per cent in north-east England, compared with 3.8 per cent in Wales. Local government expenditure in Wales now exceeds that in all English regions bar London, with about half of the differences accountable to spending on social services. Nevertheless, social services budgets in Wales are experiencing acute pressure, with cash decreasing while demands have been rising.

Policy on integrated care

There is no single Welsh policy document on integrated care, but aspects of the concept appear in many policy documents. Indeed, the creation of the unified LHBs in 2009 was intended to provide a vehicle for bringing all elements of local health services into alignment. This was not only to end the inefficient transaction costs associated with the purchaser–provider split, but more importantly to incentivise the system locally to review all aspects of the patient pathway (including prevention and health promotion) to ensure that care and support were provided where they best met the needs of the citizen.

With sustainability now at the core of the current agenda for the NHS in Wales, making a reality of this unified system for health is identified as one of seven major areas requiring change.

The integrated NHS bodies will accelerate the development of new simplified, integrated services. Confusing, disconnected services fail people and do not make best use of scarce resources.

(Welsh Assembly Government 2011b)

The need for NHS bodies to work closely with the whole of the public sector, as well as the third sector, is stressed. In this five-year vision for the NHS, 'hospitals for the 21st century' form part of 'a well designed, fully integrated network of care' – with much care moving closer to home and GP teams doing more. In addition, patients will benefit from the planned 'clinical networks', which combine staff from different units, offering people over a wide area the best blend of skills and equipment.

Health improvement strategy

The current health improvement strategy, *Our Healthy Future* (Welsh Assembly Government 2009b), builds on a wide range of existing strategies and policies in Wales, aiming to ensure that health is embedded in all policies. A number of elements within the improvement strategy closely relate to an integrated care agenda. They include the rebalancing of services within the current financial pressures, with more emphasis on promoting, protecting, maintaining and restoring health and independence; and the notion of shared responsibility – between the NHS, its partners and citizens themselves. The statutory requirement for integrated plans at the local authority level is central to the service improvement agenda, with delivery plans reflecting the particular needs of local communities. They are aggregated at the local authority level and LHB level to inform overall development and performance management.

Primary and community health services

Setting the Direction (Welsh Assembly Government 2010) is a prime example of a policy document with integrated services at its core. The document is aimed at assisting the LHBs in the development and delivery of improved primary care and community-based services – particularly for those individuals who are frail or vulnerable, or have complex care needs. The proposed system of care – a 'pull system' – is said to deliver an easily recognisable, highly organised model of integrated community services that will act as a bridge between primary care and the acute hospital. It will move towards a more proactive and preventive agenda with a particular focus on high-risk patient groups and those with increasing frailty. It describes a 'locality'-based model, led by multi-sector locality leadership teams, with comprehensive community-based resources, and joint leadership to lower the boundaries between and within organisations and professional groups. Also central to this approach are shared, secure and robust information systems across health and social care to underpin the community services, with the Informing Healthcare programme playing a key role in ensuring that enhanced access is made available to the GP record, and work under way to develop integrated 'communications hubs'.

Chronic conditions

The Welsh chronic conditions management (CCM) model and framework, developed in 2007, sets out a proactive approach to the management of chronic conditions, based on early assessment, diagnosis, and appropriate treatment within the community (Welsh Assembly Government 2007). Findings from the CCM programme of work suggest that LHBs are improving community-based service provision, the establishment of cluster-based primary care and the formation of integrated teams working across health and social care. Implementation of the CCM programme of work between 2008 and 2011 has supported mainstream change in community service delivery and the introduction

of the CCM core model of care co-ordination, integrated teams, GP clusters and locality working, as well as transferring appropriate services from secondary care settings into local community or primary care-based services. Further work is being undertaken to speed up and embed improvements more consistently across LHBs, focusing on high-risk and vulnerable groups, and to develop individual care plans for people with chronic conditions to improve the treatment, care and outcomes for these patients.

Supported self care

A key part of the chronic conditions work has been a growing recognition of the importance of self care, both in maintaining the health of those who are currently healthy and in maximising and preserving the health of those with diagnosed chronic conditions. The approach in Wales has been to develop the concept of supported self care – recognising the need for a partnership between services and citizens if the latter are to be able to sustain their own well-being equitably (Welsh Assembly Government 2009a). At the heart of the approach are four areas of such support, as shown in Table 5, below.

Table 5 Areas of support for self care, Wales

Area	Examples
1. Self-care information and signposting	Telephone advice Information prescriptions Awareness campaigns
2. Skills training – for patients, public and professionals	Disease-specific training Access to exercise Communication skills
3. Self-care support networks	Group interventions Forums/chat rooms Care/respite support
4. Assistive technologies	Home monitoring devices Computer-assisted treatment planner

Social care

The current key policy document for social services in Wales, *Sustainable Social Services for Wales* (Welsh Assembly Government 2011a), also refers to the principle of integration. In a push to renew, innovate and create sustainable services, the priority is to ensure that resources are used in a more joined-up way: ‘Sustainability depends on picking up the pace of integration.’ Social services will in future be better focused, with users and carers having a much stronger voice and greater control over their services. Renewed services will also be more efficient and effective through greater collaboration and integration of services. Social services in Wales will capitalise on the benefits of its innovative, integrated, family-based services approach. Three areas of work prioritised for much greater integration of delivery are: families with complex needs; transition to adulthood for disabled children; and frail older people. There are plans to develop an ‘information hub’, similar to that for primary health care.

Social Services and Well-being (Wales) Bill

One of the first new Bills that may gain legislative effect during 2013/14, as part of the recently acquired legislative competence of the Welsh Assembly, is the Social Services and Well-being (Wales) Bill (National Assembly for Wales 2013). Designed to provide the

organisational architecture to deliver the government's policy intentions in social care, it will provide a single statutory framework covering local authorities' responsibilities in relation to all those who need care and support, of all ages, and including their carers.

As currently drafted, the Bill contains several significant features that bear upon the provision of integrated services in Wales. It is designed not only to maximise the response of services to the manifested needs of the 150,000–200,000 people in receipt of social services at any one time, but also to extend the regard of authorities to include anyone in the population of 3 million in Wales whose well-being might benefit from it. It will include a statutory framework for 'adults at risk', and will include rights for carers that are equivalent to the rights for those who are cared for. It will enshrine the notion of 'well-being' in law, and requires the government to establish a framework for the measurement of the performance of statutory authorities in improving well-being. It gives the government powers to speed up the provision of direct payment schemes.

It also addresses the question of the degree of co-operation between health and social care. As outlined above, LHBs, local authorities and others already have to co-operate in the production of a single plan for their shared populations; this Bill goes much further, by requiring local authorities to 'promote the integration of care and support with health and health-related provision, with a view to improving well-being, prevention and raising quality' (Welsh Government 2013b, para 84). The approach is to encourage such co-operation, but the Bill gives ministers the power to force the pace if they are not satisfied with the progress being made.

Provision is made for partnership arrangements to be prescribed through regulations both between local authorities and between local authorities and local health boards. The framework is sufficiently flexible to enable the Welsh Ministers to prescribe new integrated ways of working in particular areas or across services.

(Welsh Government 2013b, para 85)

Although this Bill may not become law until 2014, and even more time may elapse before government seeks to enforce greater integration, the effect of the new powers is already being felt. Senior figures in social services and health across Wales, recognising the direction of travel, have already begun to explore locally the sorts of client groups and the types of integration that might offer greatest mutual benefit.

Health care information

Many of the current policy documents in Wales highlight the importance of appropriate IT systems for the success of integrated health care. Informing Healthcare is the NHS programme to transform health care using information and IT. It recognises that delivering high-quality, rapid and integrated health care is often hindered by a legacy of fragmentation between health sectors, organisations and services. IT, however, provides an opportunity to support service improvement and integration around the patient by developing a seamless and shared information base.

Specific initiatives to promote integrated care

Wales' experience with some types of integration goes back many years. During much of the 1980s and 1990s, health services in many (but not all) parts of Wales were delivered by 'integrated' provider organisations (latterly, NHS trusts). These brought together hospital and community health services (district nursing, health visitors, all midwifery, community therapists, and so on) under one organisation. This mix of provision in Wales, with both combined and separate providers, offered an opportunity to compare the degree of service integration actually achieved under the two models (discussed later).

For much of the first decade of the 21st century, Wales carried forward the integrated secondary/community provider model, set alongside separate commissioning bodies, which also related to primary care. While some useful progress was made under this regime in the development of more integrated care pathways, the pace of change was limited, partly because the commissioning function was generally under-powered, with 22 small teams dealing with a dozen or so much larger trusts. What the commissioners gained in understanding and support from GPs, they lost in their lack of leverage with secondary/community services, which did not always perceive the advantage in designing more integrated care.

The creation of fully integrated health bodies in 2009 saw some specific attempts to take advantage of the new, simplified and unified structures. Government decided from the start that each LHB would give its vice chair lead responsibility for primary, community and mental health services within the board. They would work closely with an executive director with an equivalent brief to ensure that the needs of these strategically significant services were met. There was concern from chief executives and others at the time that this was not a satisfactory arrangement, because it would potentially divide the board, and might allow other board members to avoid their corporate responsibilities for *all* their services. After three years of experience with this arrangement, several boards have now sought to blur these separate responsibilities, and have found other ways to try to achieve strategic change. Some have sought to emulate elements of the commissioner-provider divide – albeit within a unified board – by restructuring their executive teams to include a chief operating officer (responsible for the current provision of the entire range of services) and a planning director (who focuses on designing the optimal balance of services).

While health bodies and local authorities have had the power in Wales to establish joint funding mechanisms, few have chosen to make much use of this power. A common perception is that the difficulties and time involved in agreeing how the funds should be established often outweigh the benefits to be gained; local bodies also often argue that the gains of joint working can be obtained in other (less inflexible) ways. The Welsh Government has not sought to force the pace on this issue, although this may change when the Social Services and Well-being (Wales) Bill becomes law.

There have been a few joint appointments between health and social care; for example, in Pembrokeshire, Carmarthenshire, Blaenau Gwent and the Vale of Glamorgan. The seniority and roles of each have varied, as have their impact. Many parts of Wales have not embarked on such joint appointments, while those that have would acknowledge that generally, while they may have achieved some valuable changes, much remains to be done to achieve optimal joint working.

In parallel, there has been some movement to increase the scale of operations in social services, including moves to commission and deliver some more specialised functions on a regional basis. In addition, a few neighbouring local authorities for example, Caerphilly and Blaenau Gwent, and Powys and Ceredigion, are exploring the possibility of bringing their respective social services departments together. The regionalisation agenda has developed some momentum, but covers relatively small elements of provision; the merger agenda has greater breadth, but progress is slow, and confined to few local authorities.

At the micro level, there are several examples of integrated teams across Wales, initiated by individual clinical and professional colleagues. One such example is in Anglesey, where a consultant physician has forged a very successful relationship between secondary and primary services, providing rapid and comprehensive support in the community for ill patients, thereby avoiding hospital admission.

These examples are usually led by a small number of individuals who – often serendipitously – link over a shared client group, spot opportunities for improving care by working more closely and work together to make such change possible. Table 6, below, based on unpublished work carried out for the Bevan Commission in 2012 (see <http://wales.gov.uk/topics/health/nhswales/organisations/bevan/?lang=en>), lists both the strengths and limitations of such projects.

Table 6 The strengths and limitations of integrated teams at micro level, Wales

Strengths	Limitations
Enthusiasm	Vulnerable to changes of personnel
Shared vision	Small scale
Undaunted by procedural rigidities	Constrained by inflexible systems
Direct observation of impact and feedback	Haphazard dissemination of results

There are also some larger-scale projects, which include those described below.

Gwent Frailty Programme

A different approach is being pioneered by the Aneurin Bevan Health Board and its five local authorities in south-east Wales, using a formal pooled budget arrangement, with close involvement by the third sector. This is the largest single exploration of integrated care delivery in Wales. Funded from April 2011 with approximately £7 million of ‘invest-to-save’ money from the Welsh Government, the aim of the Gwent Frailty Programme is to create a shared resource across health and social services for older people meeting specified criteria for ‘frailty’. It is designed to:

- ensure that people have access to the right person at the right time
- focus on preventive care – wherever possible avoiding hospital admissions
- reduce the length of a hospital stay when admission is necessary
- reduce the need for complex care packages
- avert crises by providing the right amount of care when needed
- co-ordinate communication by providing a named person for all contact.

The programme began by focusing on earlier discharge of such patients and on providing alternatives to emergency hospital admission. It will also develop a hospital-at-home arm.

An assessment by WAO after 18 months of operation came to the following conclusion.

Partners are strongly committed to the Gwent Frailty vision... [It] is in the early stages of implementation and challenges remain to ensure it is sustainable, to change established behaviours and to demonstrate its impact.

(Wales Audit Office 2012a)

This was based on a sober assessment of the scale of the challenges faced by the programme, which inherited several quite different models of care across the LHB and the five local authorities. The project still struggles with some inconsistency in performance frameworks and referral criteria in practice. WAO detected some ‘tensions’ between some of the stakeholders, and some different approaches to scrutiny, and also identified the difficulties the programme may experience in establishing precisely what

has been the contribution of the programme itself to the outcomes for frail people. The review also recommended a ‘fundamental review of the IT programme’ which supports Gwent Frailty. However, there is no denying the enthusiastic support of senior figures and many clinicians for what is Wales’ cutting-edge programme in this area.

Further details of the programme are available at: www.gwentfrailty.org.uk/

Wyn Campaign, Cardiff and the Vale of Glamorgan

This is another invest-to-save scheme, serving a population of about half a million. Started in September 2011, it aims to provide wrap-around services for frail older people (the unisex name ‘Wyn’ representing everyman/woman), including facilitated discharge, an alternative falls pathway for ambulances, in-reach support to care homes to prevent admission, improved case management for people with long-term conditions, and targeted step-up responses for frail older people. Like the Gwent project, it builds on existing elements of service provision; it too is at a fairly early stage, and faces difficult challenges in expanding to provide comprehensive and uniform services.

Further details of the scheme are available at: www.cardiffandvaleuhb.wales.nhs.uk/the-wyn-campaign

Hywel Dda Health Board

Hywel Dda Health Board serves a largely rural population of just less than 400,000 in west Wales. It built on work to improve services for people with chronic conditions by developing joint health and social services provision for people in Carmarthenshire. Its focus has now broadened to embrace four elements of redesign for out-of-hospital care, including:

- population risk stratification using case finding (for frailty), GP practice lists and chronic disease registers, A&E attendance and direct ward admission data, and social care information
- surveillance and care co-ordination – including telephone case management, guided self-management and secondary prevention
- improved communication – including a new communications hub which schedules home visits, ambulance transport, and outpatient and GP appointments
- case management and navigation – including the development of a ‘virtual ward’, integrated community response teams (including multidisciplinary, multi-agency teams) and a needs-based, not criteria-restricted, approach.

Again, developments are at an early stage, and have yet to be evaluated.

Further details are available at: www.wales.nhs.uk/sitesplus/862/home

Lessons: barriers and enablers

Assessment of progress

Progress towards optimal integration of health and social care is probably best assessed in terms of beneficial outcomes, both subjective and objective. Although there is a wealth of evidence to support the beneficial impact on the patient experience of integrated care joint care workers, shared records, staff who are enabled to meet people’s needs and a proactive approach to anticipating needs there is little data across Wales with which to systematically track progress over time or between settings, since there are no consistent and comprehensive assessments of the patient experience.

There is a little more evidence on potential objective outcomes, but there are substantial problems with attributing cause and effect. One interesting indicator is the level of unplanned admissions and emergency readmissions, especially for those chronic conditions where services have devoted considerable energy to being more integrated in recent years. As Table 7, below, shows, there is some data to suggest that, on both measures, service outcomes are improving, which is particularly impressive given the long-term trend of rising numbers of unscheduled admissions and attendances at A&E.

Table 7 Number of emergency admissions and readmissions, selected conditions, Wales, 2010/11–2011/12

	Type	2010/11	2011/12	Percentage reduction
Coronary heart disease	Emergency admission	16,805	15,243	9.3
	Emergency readmission	1,882	1,517	19.4
Chronic obstructive pulmonary disease	Emergency admission	6,835	5,708	16.5
	Emergency readmission	1,887	1,422	24.6
Diabetes	Emergency admission	2,209	1,886	14.6
	Emergency readmission	405	285	29.6

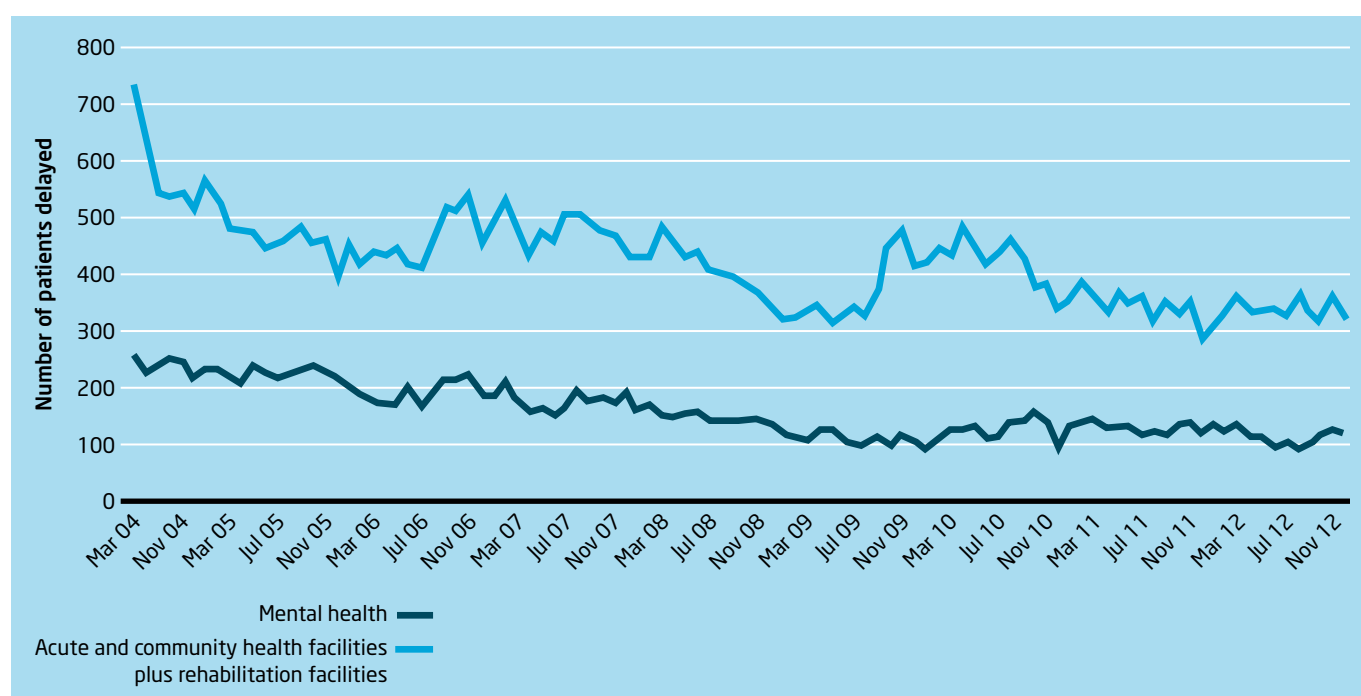
Source: Welsh Government (2012a)

There has been some scepticism expressed (for example, by the British Medical Association in Wales) about the accuracy of the data, with concern that perhaps improvements in data coding may have created some of the change, rather than different service outcomes. Even if the figures are taken at face value, the extent to which this substantial improvement may reasonably be attributed to integration is difficult to ascertain. It seems unlikely that the integrated LHBs – which after all were only created in 2010 – could have effected change so quickly. Rather, it may well reflect the several years of focus on chronic disease management highlighted above; and it may also reflect the fact that the performance management regime has prioritised this issue more recently. In either case, it is an encouraging sign that local delivery of some aspects of care may be becoming better co-ordinated for patients at greatest risk, and that change is possible.

Another key test of the effectiveness of integrated working is the level of delayed transfers of care. Significant progress was made in this area in the period up to 2008, when the topic received considerable attention. Progress since then has been disappointing, with numbers of people being delayed remaining above 300 for most months (see Figure 14 opposite). (It should be noted that in Wales, all delayed transfers are counted, from the day the patient is deemed clinically ready for transfer.)

Another key challenge is the rebalancing of services between hospital and community. Government policy has long been to effect a strategic shift in the balance of resources between acute (mainly hospital) services and those services designed to support people at the pre- and post-acute stages. This led in 2010 to a performance target to shift 10 per cent of NHS human resources in this manner within three years. This sort of vertical integration between different elements of the health care system should be something which the integrated LHBs are well placed to deliver.

There is, as yet, no overall assessment of progress against this performance indicator, partly because of uncertainty over the appropriate definitions and comparability of the various measurements. However, WAO is currently conducting a series of local studies which include a consideration of this issue. To date, they have found no evidence that the required shift has been achieved. The comment from their report on Cwm Taf Health

Figure 14 Delayed transfers of care, Wales, 2004–12

Source: Welsh Government (2013a)

Board, for example, reveals the problems in both effective planning and the delivery of such a shift, even within an integrated board.

The rebalancing of the care system set out in Setting the Direction [Government policy] will require an increased capacity within the community. Workforce plans that consider the number and type of staff in the community will therefore be vital to success. The Health Board recognises that its workforce plans do not reflect the potential service changes expected in relation to the shift from secondary to primary and community care, in particular, the 10 per cent increase in the proportion of staff providing services in the community between 2010 and 2013. The Workforce Plan for 2011–2017 shows a forecast reduction of 1.5 per cent in the number of full-time equivalent (FTE) staff in the primary, community and mental health sector by 2017. However, no real change in FTE numbers is forecast over the same period for the acute sector. Since our fieldwork, the Health Board has carried out an exercise to reconcile the numbers of staff working in the community with information held by budget holders for acute and community services. The Health Board acknowledges that one of the challenges to compiling a robust workforce plan is the need to reconcile workforce numbers with the necessary skills and competencies to deliver different models of care in primary and community care settings.

(Wales Audit Office 2012b)

It is arguably too early for the structural integration of health care – still not three years old – to be yielding the anticipated benefits. Equally, many of the benefits will be serendipitous and unrecorded, the fruits of collaboration between different teams and individuals, and there may be no data sets that capture the outcomes of such changes at this stage. However, there is a certain unease that progress has not been as rapid or far-reaching as was hoped, or as is needed, given the pace and scale of change that services now face. The introduction of new powers in the Social Services and Well-being (Wales) Bill perhaps speaks to this unease, as does the quite demanding rhetoric from

leaders in the system who are concerned about the slow pace and modest scale of progress in integration.

Six key challenges associated with integrating care are proving problematic in Wales, as elsewhere, and they are considered here.

Organisational alignment

One theoretical advantage enjoyed in Wales is the existence of integrated health bodies, having responsibility for the totality of health care provision for substantial populations. Each LHB receives a single allocation for primary, community, secondary and public health provision, and holds the contracts for all staff. It is therefore relatively unconstrained by external factors in its ability to shift or reshape services. Local authorities, however, remain separate, with different funding, accountability, eligibility and regulatory arrangements, albeit that they are required to plan jointly with their LHB.

Similarly, there is no separation into commissioners and providers within health care, and no formal power for GPs, for example, to reshape services in their own right. There is now some speculation in Wales as to whether it might be advantageous to create – albeit within the LHB – a capacity for objective and rigorous appraisal of the appropriateness and suitability of particular service configurations, independently of those staff directly involved in their provision (‘commissioning’ in a different form) and, if so, what shape that might usefully take.

At an operational level, co-location of staff is critical for integrated care delivery. This is often best achieved by having staff in the same offices and clinics, but ‘virtual co-location’ can also be an option, especially in rural areas where bringing staff together physically may not always be possible. There are some good examples of successful, virtually integrated teams in Wales, but they tend to require considerable investment in setting them up and maintaining them.

LHBs with several local authorities need to find effective ways of co-ordinating their planning and delivery. It is noticeably easier for LHBs with only two local authority partners to co-ordinate their services than for those with five or six, especially where the differences are compounded by different political allegiances.

Integration within health care remains difficult because of the persistence of cultural differences between primary, community and secondary care, lack of mutual understanding and the dominance of performance measures that are thought to relate exclusively to one sector or another. Although the LHBs have been in existence for three years, services often reflect the patterns developed by the previous trusts and smaller LHBs. The development of services for frail older people in Gwent (*see case study example, p 68*) has so far struggled to ‘level’ services across the areas that were previously commissioned by five LHBs.

Much of the ongoing support that people need is best provided by the third sector, and should generally be secured as a core part of the integrated service. Considerable effort has been expended in developing the third sector, and in improving relationships between health and third sector providers, but only a very small proportion of services is currently provided by the third sector.

Common IT platforms between agencies need to be adopted, but progress in this area has been slow. In the next two years, most people in Wales should have electronic personal health records, but in the meantime staff from different agencies usually do not have access to the patients’ full records. There have been some attempts to share such access, but this often means staff have to ‘double enter’ data onto two systems.

Alignment of incentives

Individual citizens and service users should be empowered and supported to make real choices about what support they receive and how it is provided, and systems should be effectively incentivised to respond to service users' wishes and experience. To date, however, there is no common approach to eliciting patients' views, and most LHBs only collect such data for sub-sets of their patients. The Welsh Government is now committed to much greater consistency and transparency in this area, and it is likely that patient experience data will in future be more comprehensive and comparable.

The performance management of the different agencies should be aligned so that, for example, health and social services bodies are expected to aim for the same objectives. This requires not just formal alignment (the same written goals) but also that the 'organisational body language' is aligned – each chief officer having the same 'P45 issues'. Current performance management arrangements are frequently criticised for being inconsistent, as between health and social services, demanding performance across too many (and too crude) targets, and for being too dominated by financial performance targets. There are attempts to develop 'intelligent' targets, which may reduce some of the current perverse incentives and 'blindness' to the consequences of crude targets.

Practical ways must be found to circumvent the particular problems of 'cost shunting', which are significant in difficult financial times; this problem is often ignored or downplayed. Continuing health care, for example, is often very inflexible for people whose needs go beyond 'health'. Wales makes little use of formal arrangements for shared budgets, and there are few joint appointments. This may change in the near future, as the government gives greater priority to integration between health and social services agencies.

Private provision (for example, nursing homes) is not always matched to need or resourced realistically. Many nursing homes continue to struggle to meet rising standards, and to cross-subsidise provision at the expense of private payers.

Leadership

The integration of services is a change management task par excellence, demanding all the skills and resources of any major change. The impact of a leader who really 'believes' in the importance of integration, and is determined to see it through, is evident in many parts of Wales. Staff at different levels in the LHBs report the impact which this can have. Although no leaders would deny the importance of integrated care, some have clearly made it a higher priority than others. This is an inherently fragile arrangement, however, and progress on integration in parts of Wales would be jeopardised if a few key individuals were to change jobs.

Leadership from the bottom up is also important, and staff need to be empowered to integrate services where they see the need: the coincidence of a very small number of people in a locality who trust one another and are passionate about integrated care can be very powerful, and may even obviate the need for joint appointments. For example, in one locality serving a population of about 150,000, the director of social services and the most senior NHS manager have a good working relationship and share a passion for integration, which enables possible conflicts over issues such as cost shunting to be avoided. However, there are more examples where this is not the case.

The number of service providers potentially involved in integrated care in any locality is large, and the managerial task of ensuring their co-ordination is sometimes underestimated. As a result, managers and clinicians sometimes find it easier not to try to integrate services: 'You don't do integration if you want an easy life,' one senior manager commented to the author. Some leaders report the difficulty of persuading all the senior

professionals in a service to make the sorts of changes to their professional practice that may be pre-conditions for greater integration. This sometimes takes the form of quiet resistance, and there appear to be few effective sanctions to address the issue in Wales.

Sufficient resources need to be allocated to integrated care – it is often not a cheap option, at least initially: ‘You can’t do Kaiser on a shoestring!’ another senior joint manager commented. There is now some use of invest-to-save schemes, which not only make the initial investment available, but also help to keep the focus on assessing impact. None of these schemes in integrated care has yet reached the stage where the delivery of the original business plan can be assessed.

Giving control to patients/clients and carers

Successful integration of services usually begins with a thorough understanding of what patients/clients and their carers would find useful and acceptable. Although there are many impressive examples of such endeavours in Wales, they have tended to be isolated and sporadic, and there has perhaps been comparatively little investment in systematic efforts to ensure that services meet patients’ needs and wishes.

Enabling patients/clients genuinely to be ‘partners’ in their care often requires support for the patient/client, and changes to staff attitudes and expectations, and to systems of care. This has not been an area of focus in Wales. Similarly, all services should routinely find out about the experiences of their patients/clients, should report them publicly, and should incorporate patients/clients in their performance management and continuous improvement. This has been a particularly under-developed aspect of health care in Wales, with no capacity to assess patients’ experience of care on a comparable, comprehensive and consistent basis. This may now be about to change, as the Welsh Government is committed to greater consistency in the collection and publication of such data.

Carers are a major part of service provision, but sometimes report being disempowered and excluded by professional staff, in Wales as elsewhere. They need access to information about what services are available, influence over the care provided and support for their own needs. Carers’ right to an assessment of their needs is enshrined in legislation, but receives comparatively little investment. The Social Services and Well-being (Wales) Bill is designed to ensure that carers’ rights to support are set on the same legal basis as those of patients/clients.

Case management

Integrated care often depends on effective case finding, assessment for targeting of care, care planning and co-ordination. The first of these has been a significant challenge in Wales. Very few parts of the country have yet identified those individuals in their communities who are on the brink of becoming major service users (case finding) and for whom they could provide targeted support to maintain their well-being and independence. There has been sporadic adoption of clinical risk assessment tools such as PRISM to enable GPs to risk stratify their own populations, but none has met with universal support and as yet there is no generally accepted tool for the purpose. Individual LHBs are now starting to develop their own hybrid approaches, drawing on various data sets to provide some consistency of approach.

Having case managers who co-ordinate all the support for an individual can be a simple and effective way of integrating care, and patients and carers report positively on the immediate impact that one well placed and sensitive professional can have in co-ordinating otherwise disparate services, and ensuring that those services are delivered in a way that meets their needs. Case managers working across agency boundaries

are found in some parts of Wales, but are not yet a normal and expected element in provision.

Telecare is currently under-utilised and its potential is unevenly understood across Wales. Given the rurality of much of Wales, and the significant difficulties in accessing hospitals experienced by isolated and deprived communities, telecare has particular salience. There is some evidence to suggest that further progress in the wider, appropriate adoption of these technologies now depends on tackling resistance from key staff groups who are not convinced of the merits of working differently.

Persistence

Integrated care typically takes five years or more to deliver its objectives and become self-sustaining. In some parts of Wales, services are reluctant to embrace integrated working, often either because they are nervous about the ability of other services to deliver for their clients or they are worried about the possible reduction in their own resources. Persuading them of the desirability of change takes a long time.

Medium-term planning is often undermined by staff turnover, short-termism from above or the overwhelming impact of annual financial targets. Brokerage, invest-to-save schemes and other mechanisms can help people to focus on the slightly longer term. Helpfully, there is no prospect of further structural reorganisation of health services in Wales, which avoids one major possible source of turbulence, although there is some exploration of mergers between social services departments.

Conclusions

Wales enjoys some considerable advantages in its journey towards optimising integrated care. The fact that almost all of the population is registered with a GP should make it easier to identify people at risk of becoming vulnerable; work on the management of chronic diseases leaves a legacy of joint working and understanding; and there is little prospect of forthcoming reorganisation of health bodies or (at least until after the 2015 Assembly election) of local government, providing a valuable element of consistency and longer-term planning. Each of these is an asset.

In addition, there are several potential strengths – opportunities – which have yet to be fully exploited. The greatest of these is the integrated LHBs, which have no financial or performance disincentives to ensuring that services best meet patients' current and future needs, and which are large organisations with access to specialist expertise and data in abundance. In addition, the NHS and social services are now focusing more seriously on capturing the patient's/client's experience, measuring outcomes and empowering service users to ensure that services meet their needs – all key elements in integrated care. The commitment of the government to this policy area, the availability of (limited) resources for invest-to-save schemes (essential if the initial costs of service redesign are to be met) and the encouraging development of locality networks, serving populations of about 50,000, are all further opportunities.

On the deficit side, there are several weaknesses. At present, seven LHBs are having to relate to 22 local authorities, have little experience in or appetite for pooled budgeting, and labour under multiple information systems, each serving elements of the integrated care package. There is currently little agreement on how to risk stratify the population, and areas within Wales have an often-remarked-on reluctance to adopt good practice from elsewhere. Progress to date in integration has often depended on the abilities of individual leaders and the coincidence of their shared workplace, criteria which are unpredictable and fragile.

Finally, two significant threats loom. First, the severe financial pressures, especially on health, may crowd integration off the NHS's agendas; and second, the managerial attention currently being given to controversial proposals for hospital reconfiguration may also divert attention elsewhere.

At the heart of this situation lies an old paradox. While most leaders in health and social care in Wales readily accept that greater integration would deliver better care for their patients and clients, and would be a key element in solving many of the other problems which currently confront them, it often seems just too difficult to make the initial step change that is required.

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4 Drawing out the lessons

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As this report shows, integrated care in the United Kingdom has developed in a variety of ways:

- Northern Ireland has had integrated health and social care since 1973 but there has always been a commissioner–provider separation throughout this period.
- Scotland has had an integrated NHS structure since 2004 when the commissioner–provider separation was ended and unified health boards created but local authorities continue to have responsibility for social care.
- Wales has followed the example of Scotland since 2009 with the creation of unified local health boards and again local authorities continue to have responsibility for social care.

One of the challenges facing the authors of the papers in this report is the lack of well-designed studies and evaluations of the impact of integrated care in all three countries. In the absence of such studies, it is necessary to rely on routinely available data, often collected in different ways in each country and therefore difficult to compare. As others have found before us (Connolly *et al* 2010; National Audit Office 2012), this presents formidable difficulties in making comparisons, let alone reaching consensus on how these should be interpreted.

The papers published here seek to assess impact by examining selected data on service use such as emergency bed use in hospitals and delayed transfers of care and how this has changed over time in different countries, where it is available. Yet even when changes in this data can be detected, there is the challenge of attributing them to progress on integrated care versus other developments, for example, in relevant policies, occurring at the same time. As well as statistical data, the papers provide examples of innovations in care in each country and draw on the assessment of the authors to reach conclusions on which this final chapter of the report is based.

Northern Ireland

Despite having the longest history of integrated care, Northern Ireland has been slowest to exploit the potential benefits. This reflects the fact that responsibility for social care was taken out of local authorities because of concerns about their capabilities rather than as a positive intention to promote integrated care; there was also a lengthy period of policy inactivity both before and after the creation of the Northern Ireland Assembly, with few examples of either direct rule or devolved governments seeking to use the integrated structures to develop integrated services. The political context of ‘the troubles’ and a focus on ending them and giving priority to other issues such as economic development meant that health and social care policy took a back seat until recently.

There are some local examples of innovation but little systematic evidence that integrated health and social care has demonstrated measurable improvements for the population.

Indeed, in some respects developments in policy and service change have lagged behind other parts of the United Kingdom, examples being care of people with mental health needs and learning disabilities, and care of children and young people. In many respects, therefore, Northern Ireland represents a missed opportunity to demonstrate on a system-wide basis what can be achieved when the organisational barriers to the integration of health and social care are removed.

Scotland

Scotland appears to have made the greatest progress and this can be attributed to: organisational stability since 2004; a political consensus on the importance of integrated care; the commitment of successive ministers and leaders in the NHS and local authorities; and the promulgation of a series of policies designed to promote and support integrated care. These policies include a national performance and outcome framework directed towards an explicit purpose for Scotland.

This is supported by 16 national outcomes and 50 national indicators and targets, a significant number of which relate to health and social care. At a local level the performance framework is translated into a Single Outcomes Agreement between the government and community planning partnerships. The latter are led by local authorities and involve a wide range of statutory partners and voluntary and private sector organisations.

Managed clinical networks are one of the means used to promote closer integration (mainly within the NHS) in Scotland. Despite this, it is clear that existing arrangements for joint working between the NHS and local authorities centred on community health partnerships are not working as well as desired, hence the development of plans to change the law to require the introduction of health and social care partnerships to bring together responsibility for health and social care services, initially for adults. It is also clear that health boards have struggled to bring about any significant shift in resources from hospitals to the community.

The impact of policies pursued in Scotland is evident in changes outlined in Chapter 2 on emergency bed day use and delayed transfers, increased use of home care, and lower than projected use of care homes. The extent to which these changes can be attributed to initiatives related to integrated care remains uncertain but they do indicate that benefits are being realised.

Wales

Wales is still at an early stage in the development of integrated care. As in Scotland, there is a supportive policy context and there are promising examples of local innovation. There is also some evidence that emergency admissions and readmissions from conditions such as chronic obstructive pulmonary disease and diabetes have started to decline substantially, although many factors lie behind this.

On the other hand, as in Scotland it has been difficult so far to shift resources within local health boards from hospitals to the community, let alone from health to social care. Lack of alignment between local health boards and local authorities (7 compared with 22), different funding streams and long-standing professional loyalties are some of the barriers that hinder more rapid progress in Wales, despite a strong political commitment and leadership from within the Assembly.

Unlike in Scotland, Wales does not have a single outcomes and performance management framework and this is a further obstacle to progress.

Implications

As this high-level summary suggests, it is important not to over-claim what has been achieved in these three countries. Even when some of the organisational obstacles have been removed, there remain formidable challenges in realising the anticipated benefits of integrated structures, including shifting resources from hospitals to the community. It is hard to exaggerate the power of acute hospitals within the NHS: structural change will do little to affect them unless politicians and health and social care leaders are prepared to manage the unpopularity that is often associated with plans to reduce reliance on hospitals and implement new models of care in the community.

The need for caution in interpreting the experiences of Northern Ireland, Scotland and Wales is underlined by studies comparing the performance of the NHS in these three countries with each other and with England. Although a matter of continuing and sometimes heated debate, it appears that on some key indicators the NHS in England outperforms the NHS in the rest of the United Kingdom, notwithstanding expenditure levels that have historically been lower than those in the other countries (Connolly *et al*, 2010). While the performance management regime developed in England, sometimes referred to as ‘targets and terror’, is often invoked to explain improvements in performance, it should be noted that similar regimes have been used in the other countries. The benefits of integrated care such as those that have been realised in Scotland therefore need to be weighed against what appears to be more limited progress in some other areas of care.

Lessons learned

An important lesson from this report is that structural integration either within the NHS or between health and social care is only one factor among many in facilitating the development of integrated care. It is also apparent from the experience of Northern Ireland that integrating health and social care within the same structures may have the unintended consequence of social care becoming subservient to health care. There is an obvious and important caution here for England at a time when debates about health and social care integration are gathering pace.

It is clear that structural integration in itself may bring few if any benefits unless it is accompanied by other changes. These include:

- coherent policies designed to promote and support integrated care, such as those developed in Scotland during the past decade – including a national performance framework and a single outcomes framework
- governance arrangements that enable different organisations (especially local authorities and NHS bodies) to work together to develop joint strategies in order to make a reality of integrated care
- political, managerial and clinical leadership at all levels that ensures a clear and consistent focus on integrated care
- organisational stability to avoid the distractions and delays that occur when structures are altered frequently
- a willingness to challenge and overcome professional, cultural and behavioural barriers to integrated care both within the NHS and between the NHS and social care
- a commitment to integrated care as a policy priority for government as a whole (as in Scotland and, to an extent, Wales)

- maintaining this commitment over a sufficiently long period to enable policies to have a measurable impact
- a willingness to provide financial support and flexibilities to enable the introduction of new models of care – examples being the Change Fund in Scotland and ‘invest-to-save’ schemes in Wales
- action to share information both within the NHS and between health and social care, an issue on which Scotland appears to have made more progress than other countries
- an ability to manage the differences and tensions that arise when different public services are organised differently, an example being the persistence of a commissioner–provider separation in local authorities but not in the NHS in Scotland and Wales.

It is clear that demonstrating the benefits of integrated care depends on action on most if not all of these issues. This is illustrated by the experience in Northern Ireland which has had a large measure of organisational stability and a long-term commitment to health and social care integration, but where the other factors we have identified have failed to be systematically addressed.

To these lessons we would add the importance of giving greater priority to evaluating the impact of structural and related changes to promote integrated care in order to assess what impact they are having. Although there is a growing body of evidence in this area (Curry and Ham 2010), we have been struck in bringing together these papers by the lack of well-designed studies of impact. In the absence of reliable evidence, debate about the relevance to England of experience in other parts of the United Kingdom will continue to be contested.

The question that arises is whether England would be better advised to promote and support integrated care not by further organisational change but by acting on the many other factors that are identified here as either facilitating or hindering progress. Readers will arrive at their own answers to this question but on the evidence presented in this report it is hard to argue persuasively that *restructuring* health and social care should be a high priority. Far more important is to address the myriad barriers (financial, cultural, and so on) that in most parts of England make integrated care the exception rather than the rule. The challenges in so doing should not be underestimated given the lessons enumerated above and the obvious difficulties in acting on these.

In this context, it can be argued that the most critical role of national policy-makers is to remove the barriers that inhibit progress, establish a policy context that is fully aligned with the aims of integrated care, and through their policies and actions demonstrate that integrated care is a core objective for government. A start has been made in this direction with the announcement in May 2013 by Norman Lamb, the Care and Support Minister, of the government’s plans for integrated care supported by collaboration between 14 national partners. What now needs to happen is to convert the high-level vision and aspirations contained in these plans into specific changes that will enable integrated care in England to be taken forward at scale and pace.

As The King’s Fund has argued in previous work (Goodwin *et al* 2012), this should include attaching the same priority to integrated care over the next decade as was given to the reduction in waiting times for treatment during the past decade. Setting a clear, ambitious and measurable goal to improve the experience of patients and service users should be an early priority, linked to goals relating to the outcomes of care and service utilisation. Also important is to put in place financial incentives that support integrated care by moving away from an over-reliance on payment by results and making use of capitated budgets and other forms of payment appropriate to this purpose (Appleby *et al* 2012). Ministers must also ensure that rules on procurement and regulation are applied

in a way that balances the need to stimulate competition in some areas of care with the imperative to support collaboration and integration in other areas.

To use a medical analogy, the focus now needs to be on ensuring that the physiology of health and social care is fit for purpose rather than seeking to alter the anatomy. To be sure, anatomical changes may be needed at some point in the future but the clear message of this report is that on their own they are unlikely to be sufficient. Evidence from various studies underlines the fact that patients and service users benefit when the emphasis is on clinical and service integration rather than organisational integration (Curry and Ham 2010) and also that examples of successful clinical and service integration remain relatively rare. All the more important, therefore, that the pioneer communities to be established in England are given sufficient time and support to demonstrate what can be achieved in the next stage of health and social care reform. The lessons distilled in this final chapter offer both guidance and warnings as the pioneers embark on their journeys, illustrating both the opportunities on offer and the hurdles to be overcome.

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