

# EAST AYRSHIRE COUNCIL

CABINET: 15 JUNE 2011

## INTEGRATED RESOURCE FRAMEWORK

### Report by the Executive Director of Educational and Social Services

#### 1 PURPOSE OF REPORT

- 1.1 To provide an update with respect to the work undertaken in East Ayrshire in connection with the Integrated Resource Framework.
- 1.2 To seek endorsement of the proposed actions resulting from the work undertaken during 2010.

#### 2 BACKGROUND

- 2.1 The Integrated Resource Framework was developed by the Scottish Government, NHS Scotland and COSLA, through the National Shifting the Balance of Care Delivery Group. It is a response to the shared strategic objective to shift the balance of care from institutional to community settings by working in a more integrated way within the NHS and across health and social care. A key driver is the belief that more effective integration can improve people's experience of services, and enable better models of care to be provided without necessarily incurring additional cost.
- 2.2 The ideas behind the Integrated Resource Framework are fundamental. The framework enables partners to answer the questions,
  - How are we using our resources?
  - What are our resources achieving?
  - How can we plan and invest our resources in a different, more effective way to support shifts in the balance of care?
- 2.3 On 2<sup>nd</sup> December 2009, cabinet endorsed the East Ayrshire Project Initiation Document which detailed the plan for East Ayrshire Council in partnership with NHS Ayrshire & Arran to undertake activity within phase 2 of the Integrated Resource Framework Programme for Ayrshire & Arran. On 11 February 2011 Governance and Scrutiny Committee endorsed a framework of Financial Protocols and Mechanisms to support joint working with the NHS.
- 2.4 The purpose of the project was to deliver improvements in services to adults with complex care needs in East Ayrshire by enhancing and strengthening partnership working.

## 2.5 Anticipated outcomes of the project were:

- Resource allocated in line with relative need
- Increase sustainability of service delivery
- Efficient utilisation of resources and best value evidence based models of care introduced.
- Approaches to link resources to the individual's care examined and identified

2.6 The project spanned the remit of the East Ayrshire Mental Health and Learning Disability Partnership, taking into account people aged between 16 and 65 who were affected by learning disabilities, mental illness and autism. As such the project was fully integrated in to the East Ayrshire Community Health Partnership.

## 3 PROGRESS

3.1 In January 2010 a small project team comprising three well established practitioners from both health and social work services was created. They were located within North West Kilmarnock Area Centre in order to ensure a high profile identity with operational teams engaged across the NHS and Council with adults affected by learning disabilities, mental illness and autism who are already co-located in the centre. It was also important that they were seen to be located within a joint resource, and not one partner imposing a policy and practice on the other.

3.2 The project team was overseen by an East Ayrshire Senior Manager and a NHS Health Care Manager and with support from both organisations' operational managers.

3.3 Between January and July 2010, the project team via operational teams identified 377 people who were considered to have complex needs as a consequence of their legal status, multi disciplinary involvement and location i.e. inpatient in a long stay hospital bed.

3.4 The project team met with staff groups across the NHS and East Ayrshire directly involved in service provision along with representatives from the CHP Carers' sub group, Advocacy Services, independent sector providers and organisations operating outwith East Ayrshire.

3.5 The Project Team also scoped the investment from a health and council perspective on support provision and staffing arrangements across the organisations.

3.6 Crucially the Project Team maintained positive communications with staff across services about their activities. This addressed concerns and misunderstandings which were expressed in the early stages that the exercise was focused on cost cutting rather than equitable allocation of resources in line with need and where required redistribution of resources to meet identified priorities.

- 3.7 The Project Team produced an initial draft report in September 2010 detailing their actions, research and findings. The full report is available on the members portal.
- 3.8 An Implementation Plan was developed from the report and supported by the Ayrshire and Arran Integrated Resource Framework Steering Group on 1 February 2011(Appendix 1).

#### **4 OUTCOME OF ACTIVITY**

- 4.1 Key findings from the work undertaken by the project team identified several major issues relating to health and social care support provision.
- 4.2 The review undertaken by the IRF team identified a risk averse culture which requires to be addressed. There were occasions where overnight care had been rarely if at all called upon and people isolated from their communities on account of a complete dependence on paid support.
- 4.3 The Project team identified a need to shift the culture across both organisations from risk averse to risk managed, increased enablement activity to promote and facilitate independence and enhanced engagement with the community, to reduce dependence on paid support. In addition, support providers require to work together, particularly where they support people within a close geographical area.
- 4.4 Decision making in terms of Resource Allocation was found to be undertaken by one agency – Social Work, resulting in a feeling of a lack of influence and subsequently ownership from partners. In order to reinforce the joint investment and responsibility for support packages, NHS colleagues will join the Resource Allocation Group where care packages are considered for funding. In addition a programme of joint reviews will be progressed within a specific location where there are a number of people located with supports provided by a range of support providers and it is anticipated this will inform and support the development of more sustainable support models.
- 4.5 In order to support the development of personalised supports, including the use of Self Directed support through individualised budgets, the establishment of a Resource Allocation System, which will inform the level of funding in line with indicators of care needs will be developed, ideally across Ayrshire. This will inform the procurement process for support providers scheduled for Spring 2012.

#### **5. NEXT STEPS**

- 5.1 The Implementation Plan will now be progressed led by the original seconded project team reporting through the East Ayrshire Mental Health and Learning Disability Partnership.

## 5.2 The agreed direction of travel is:

- To take forward a process of joint reviews of people with complex care needs to ensure support packages enable safe, personalised and cost effective care and are proportionate to identified need
- Establish a Resource Allocation System which will enable all service users to know what funding they will receive for their care, based on publicly available criteria and with the option to utilise existing services or purchase and direct their own support.
- Extend the existing Resource Allocation Group to include key stakeholders such as health, housing and leisure services.
- To work with a system of aligned budgets across the NHS and East Ayrshire Council taking shared responsibility and ownership for jointly commissioning an effective framework of services. It is anticipated this is a step towards the establishment of full joint budgets.
- To move to greater devolved responsibility of the budgets to locality teams.
- Building on existing good practice in respect of co-location of services.
- Maximising opportunities presented by improvements in telehealth and telecare to provide service users with the least restrictive and intrusive support possible.

5.3 This activity scheduled for 2011 will improve joint ownership and responsibility for the care and support of vulnerable individuals in East Ayrshire while ensuring resources are targeted.

5.4 In conjunction, independent sector and statutory service providers will be supported to refocus their activity to ensure it supports an enablement model, reducing the dependence on paid service providers.

5.5 A Critical part of the Implementation Plan will be full engagement with service users and family carers.

## **6 FINANCIAL IMPLICATIONS**

6.1 The total resources managed within Mental Health and Learning Disability Partnership across agencies in 2009/10 was identified through the phase 1 Integrated Resource Framework to be £13.4M.

6.2 Resources of £40K have been made available from Scottish Government to East Ayrshire in support of the Integrated Resource Framework programme and specifically the implementation arrangements at paragraph 5.1.

- 6.3 Operational services have been supported in the delivery of the Integrated Resource Framework programme by colleagues from Corporate Finance who have developed a framework “Financial Protocols and Mechanisms to support the Integrated Resource Framework” that was presented to Governance and Scrutiny Committee on 11 February 2011.
- 6.4 The success of service redesign in adult services to meet increasing demand is fundamental to the delivery of sustainable social work services

## **7 POLICY / LEGAL IMPLICATIONS**

- 7.1 The Integrated Resource Framework promotes shifting the Balance of Care Policy, with resources moving from institutional investments and models of care to sustainable community based models of care which provide personalised support.
- 7.2 All elements of service redesign will reflect the move towards a safeguarding culture in line with the principle of Adult Support and Protection. Adults with Incapacity, and Mental Health Care and Treatment legislation along with the “Same as You”. Review of services for people with learning disabilities.

## **8 RISK MANAGEMENT IMPLICATIONS**

- 8.1 All service developments will be assessed and managed to take account of both individual and organisational risk
- 8.2 It is recognised that service pressures and resource demands are increasing in respect of community health and social care. The actions as progressed, support service sustainability and mitigate against financial risk

## **9. COMMUNITY PLANNING IMPLICATIONS**

- 9.1 The Integrated Resource Framework contributes to the aims of the Improving Health and Wellbeing and Improving Community Safety Themes of the Community Plan.

## **10. EQUALITIES IMPACT**

- 10.1 As service models are developed they will be subject to an Equalities Impact Assessment.

## **11. RECOMMENDATIONS**

It is recommended that Cabinet:

- (i) note the progress made within East Ayrshire with respect to the Integrated Resource Framework
- (ii) endorse the East Ayrshire Integrated Resource Framework Implementation Plan (Appendix 1)

(iii) otherwise note the contents of this report

**GRAHAM SHORT**  
**EXECUTIVE DIRECTOR OF EDUCATION AND SOCIAL SERVICES**  
**2 June 2011**  
**EF/AF/JQ**

**LIST OF BACKGROUND PAPERS**

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**IMPLEMENTATION OFFICER: EDDIE FRASER, HEAD OF SERVICE:**  
**COMMUNITY CARE**

<b>EAST AYRSHIRE INTEGRATED RESOURCE FRAME WORK – IMPLEMENTATION PLAN</b>
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Outcomes	Input	Process	Lead	Timescale	Output	Priority High Medium Low
1. Support is provided from within the community and is not restricted to paid services.	Staff support and time for service users to establish Social Firm.	Compile a directory of community opportunities.	Making it happen Group.	June 2011	Mapping of community opportunities.	High
Capacity Building	Service provider time and facilitation of development session for NHS, Local Authority, and paid providers, to support culture shift (£10k)	Raise awareness of the need for all partners (including the third sector) to engage with the community.	IRF implementation team with Altrum and Social Firm	Oct 2011	Partners utilise and build positive community relationships.	Medium
2. Partners better placed to support community development through enhancing existing community capacity resources	Staff time and energy to review roles and functions.	Review roles and functions of all community development and liaison posts across NHS, EAC and Independent Sector.	IRF implementation team with Doreen Boon and Catriona Josh	Oct 2011	Roles of range of community coordinators clarified and re-focused to ensure shared experience, joint approaches, and consistent community coverage.	Medium
3. Communities are	Staff time to collate	Raise awareness of routes to	IRF	December	Community has more	Medium

supported by small grants to develop activities.	and present information	access funds.	implementation team with other relevant personnel	2011	capacity to develop it's own resources.	
4. Role of community supported/enhanced through use of monies associated with individual care packages)	Service provider resources in terms of time.	Service providers proactively engage in the community where they are located.  Contracts reviewed to include a requirement for this activity.	IRF implementation team with East Ayrshire Commissioning and Review Team	December 2012	Providers have established and active role in the community.  Service users have greater involvement with their local community	Medium
5. Preventative and enablement interventions to be developed and implemented by NHS, EAC and providers reducing risk of crisis interventions being required.	Existing staff resources. Joint training and awareness raising as required. Recovery Co-creating health Telehealth Core and cluster Titchfield Street – supported by Mental Disorder Home Support Team	Culture of prevention and enablement jointly established across all services.  Workforce refocused to facilitate the above.	IRF implementation team with Adult Mental Health and other partners	December 2012	Service Users enjoy better health through the pro-active acquisition of skills which contribute to crisis avoidance.  Staff workloads are shifted towards a more manageable balance through the prevention of crisis for some service users.	Medium
6. Partners' records are all electronic	System capacity to facilitate electronic recording. IT staff time. Staff time to transfer information, if necessary.	System established to secure safe electronic recording.	IT Section	Refer to Data Sharing Partnership	Case file recording will be a singular electronic process.	High priority but timescale outwith IRF control

<p>7. Data sharing is improved between agencies with instant clarity available to all partners about care plans, changes to situations and information sharing.</p> <p>There is an electronic, accessible, diary of support available to all parties providing input.</p>	<p>System adapted to provide a shared access point in line with the Multi Agency Pre Referral Group system. IT staff time across agencies</p> <p>Staff time to populate and maintain support plans.</p>	<p>System established to enable shared access to support plans</p>	<p>IT Section</p> <p>All partners staff</p>	<p>June 2011</p>	<p>Reduced duplication and more efficient use of staff inputs.</p> <p>Readily available performance /management and monitoring tool.</p>	<p>High</p>
<p>8. Services appear seamless to the public through promotion of co-location and other opportunities for sharing</p>	<p>Facilities including staff, budgets and buildings are jointly resourced.</p>	<p>Existing co-location opportunities are fully utilised.</p> <p>Any future developments are considered on a shared basis.</p>	<p>All partner agencies</p>	<p>immediate</p>	<p>Improved access for the public to services. Increased efficiencies for all agencies.</p>	<p>High</p>
<p>9. Care management activity is undertaken across NHS and local authority services.</p>	<p>Training across all staff groups re care management roles and responsibilities.</p> <p>Grade 8 post to focus specifically on income maximisation and implementation of</p>	<p>Train and reassure all staff of the care management role and function in line with principles of enablement.</p> <p>Establish a joint post to undertake financial specific activity related to care management in order to facilitate its further uptake</p>	<p>IRF Implementation Team with operational managers and training staff</p>	<p>December 2011</p>	<p>More efficient use of staff across agencies.</p> <p>Income maximisation and charging applied appropriately</p>	<p>Medium</p>

	charging policy.  Staff capacity to access training sessions.	in the NHS, and streamline care management practice in general.				
10. Joint budget available across MH and LD services for fast access.	Extension of the current Joint Protocol Budget to include Mental Health (20k)	Protocol for Joint Budget extended to include Mental Health	EAC and NHS budget holders	April 2011	Fast access to funds to provide support to prevent admission and facilitate discharge.	High
11. Services focus on enablement and providing opportunities safely as opposed to identifying reasons not to do something.	Training sessions across agencies (10k)  Staff time to attend sessions	Multi agency awareness raising and training sessions to support culture shift relating to risk enablement.  All tiers of agencies to engage in the process.		December 2011	Shared understanding and culture across all services with respect to risk.	Medium
12. Contracts for service providers reflect an enabling and rehabilitative culture and not a direct service provision arrangement.	Staff capacity to review tendering arrangements.	Contract and tendering arrangements are reviewed to take account of a person centred, enabling approach.  Hourly rates will not be payable, rather individual budgets which will encourage the development of natural supports.	EAC Contracts and Commissioning Service  IRF Implementation Team	June 2012	Services will be commissioned on a person centred way with the emphasis on enablement and not retaining and increasing paid support.	Medium
13. There will be a transparent allocation of resources for individuals based on assessed need.	Staff capacity to establish a Resource Allocation System including NHS resources	Based on learning across Britain a Resource Allocation System is established within East Ayrshire.	RAS	August 2011	Resource allocation is a transparent process. Individualised budgets are allocated based on need and can be utilised	High

	<p>Multi agency staff accessing training and awareness raising re self directed support.</p> <p>RAS linked to</p>	<p>The system is transparent and publicly accessible.</p> <p>People accessing services know what their allocation is and agree how their jointly agreed outcomes are going to be met.</p> <p>Self Directed Support/Direct Payment staff undertake awareness raising programme across all services and carers.</p>	<p>Direct Payments Staff and AILN</p>	<p>August 2011</p>	<p>in a flexible way to meet needs.</p> <p>All staff, across agencies are confident with the options for self directed service provision.</p>	
<p>14, Carer support is recognised and bolstered as required</p>	<p>Carers forum capacity to redefine meaningful carers support plans/assessments.</p> <p>Carers time to deliver awareness raising and training sessions.</p> <p>Staff time to learn about the redesigned carers support model</p>	<p>Carers Forum to adapt the current carers assessment tool and process to meet need.</p> <p>Carers, supported by officers to deliver awareness raising sessions to staff about the carers role and the revised tool.</p>	<p>Carers Forum and officer support.</p> <p>Cross agency training officer capacity</p>	<p>Aug 2011</p> <p>Dec 2011</p>	<p>Carers are all confident that their needs are considered and responded to proportionately.</p>	<p>High</p>

15. Service users and carers live with the least restrictive and intrusive support possible.	Staff capacity to access awareness raising sessions regarding telehealth/care  Staff capacity to deliver awareness raising sessions.	The EA Telehealth/care strategy takes account of the LD and MH population to ensure all developments are inclusive and jointly accessible.  All relevant assessment processes include a consideration of the applicability of telehealth/telecare	Telehealth/Care Sub group	March 2011	Real and safe options to paid staff in the home are available to people as part of a support package.	High <b>Achieved</b>
16. Data sharing is improved and accurate and supports service design	Staff capacity to audit existing local data sets and reporting processes	Audited data sets and reposting processes are collated to provide an informed record of EA needs and service requirements.	EA and NHS information managers	June 2011	There is a core data set which can be jointly accessed in order to inform returns and plan service delivery.	Medium
17. Multi agency reviews are undertaken timeously and within the context of an enablement culture.	One social work and one NHS employee, with supporting structure.  Independent.	Personnel collocated and charged with undertaking a programme of reviews of supports.	IRF Implementation Team	March 2011	Reviews of supports are multi agency and reflect enablement as opposed to maintenance.	High <b>Achieved</b>
18. Resources are mapped geographically	Staff capacity to undertake and maintain map	There will be an up to date map of service provision to enable fast consideration of potential shared supports and providers within areas.	IRF Implementation Team	July 2011	There is a formal, recorded map of resource provision across EA which will improve efficiency when additional	High

					services are required within one area	
19. Resource allocation is considered within the context of wider community supports.	Staff capacity to re-establish the RAG into a broader model.	Request for support are considered across existing agencies and services.	RAG	September 2011	Access to supports are considered on a broad basis and is not restricted to paid providers.	High
20. Agreed definition across agencies with respect to concepts of complexity	Staff capacity to deliver and attend multi agency awareness raising sessions.	Support provision is not determined by a label of complexity.  Across agencies there is a shared understanding of service provision on the basis of need and context.	RAS  Multi agency training resources.	Sept. 2011	Complexity is not a tool to drive up support levels.	High/Fast
21. IRF Steering Group leads the implementation of the action plan	Multi agency staff capacity	The IRF Steering group in EA is located within the MH and LD Partnership. It is populated by local decision makers, including reps from the independent sector, service users and carers.	Head of Service EAC and Director NHS	Jan 2011	There is a clear reporting route for implementation within the CHP structure.	<b>Achieved</b>
22. Service users, carers, and staff are all engaged in supporting and taking forward the IRF agenda	IRF team and supporting staff engaged in communication activities.	Staff and service users / carers engaged with through a variety of means: newsletters; attendance at team meetings; liaison with carer groups, service user groups; provision of launch event for process	IRF Implementation Team	July 2011	Stakeholders at all levels within all relevant contexts have access to opportunities for learning more about the IRF project outcomes and actions	High

23. Progression of the IRF implementation plan is adequately supported	NHS and local authority staff	Through the maintenance/development of a team of individuals tasked with progressing the IRF, achievement of the actions associated with the project implementation plan are ensured	Partner agencies	Feb 2011	A team dedicated to the progression of the IRF agenda is maintained/developed	High <b>Achieved</b>
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