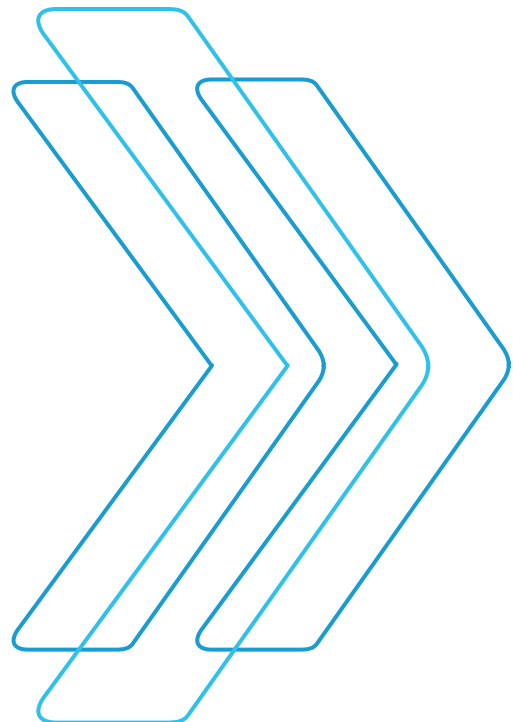


Leading across health and social care in Scotland

Learning from chief
officers' experiences,
planning next steps

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June 2018



This independent report was commissioned by the Scottish Government, in collaboration with chief officers of Scottish integration authorities. The views in the report are those of the authors and all conclusions are the authors' own.

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1 Introduction and context

About this report

When Scotland's integration authorities had been established for a year, the Scottish Government and the integration authorities' chief officers asked The King's Fund to work with them on embedding and developing their roles by exploring three key questions.

- What does the next level of maturity look like for the chief officers' roles?
- How can the chief officers strengthen their leadership role and achieve their potential to lead whole-system change in health and social care across Scotland, both in their local integration authorities and by working as a network to co-ordinate, share learning and engage with national issues?
- What is the shared purpose/shared ambition for the chief officers and their network?

The chief officers came together to consider:

- their individual roles, as leaders in their areas
- how they and local integration authority partners are developing their roles together
- how the network of chief officers is developing at national level
- how they are working with regional and national partners
- how they are working with wider stakeholders, such as their communities and third sector partners.

This report sets out how the chief officers have developed their role in the Scottish health and social care system so far – a narrative of their approach, achievements and direction of travel, as they described it to us. It also draws on research and analysis by The King's Fund on integrating health and social care and system leadership, as well as policy guidance from the Scottish Government.

It describes a baseline of achievements and work in progress at a time when chief officers have been formally in post for a little more than a year. This includes describing a number of examples to illustrate what their approach looks like in practice.

The report goes on to suggest what the chief officers could focus on next to develop their role and the integration agenda, both locally and nationally. In the concluding section, it discusses areas of strategic importance for the shared future ambition for the network of chief officers and makes recommendations to strengthen and further embed their roles.

As an appendix, the report considers similarities and differences between the Scottish and English approaches to integrating health and care systems, as part of The King's Fund ongoing encouragement of learning between the two countries.

Background

In 2014 the Scottish Government legislated to require local authorities and NHS boards to plan, monitor and resource some services jointly (Scottish Government 2015b). This was the latest stage of a long-term priority that the Scottish Government and politicians have given to integrating health and social care services since devolution (Audit Scotland 2018). It was in the context of the Christie report on the future of public services (Scottish Government 2011) which set out a vision for collaborative public services that are more responsive to individuals and communities, prioritise preventive approaches and reduce inequality. In relation to health and social care, this approach broadens the traditional view of medical and social care models and positions their integration within a movement of community-driven change. It emphasises a style of collaborative leadership and a renewed public sector ethos, which are required for services that will empower citizens and communities to realise their potential.

Integration of health and social care is a key priority for the Scottish Government and significant infrastructure –including a national delivery plan and outcome and integration indicators for monitoring progress – has been established to support it. Reviewing our conclusions when we reported on lessons for England from the other UK countries' approaches to integration (Ham *et al* 2013), it was noticeable that Scotland had made progress in all the policy and systems issues identified as important (and yet, unsurprisingly,

the aspects that cannot be legislated for, notably developing relationships and embedding cultural change, continued to require work).

Legislation requires a minimum set of adult services to be integrated in all areas, including primary and community health services, social care and a set of medical acute specialties. The health services particularly include those for long-term conditions and account for the majority of unplanned hospital admissions. The objectives of managing increasing demand – for long-term conditions management and for social care in particular – and reducing avoidable hospital activity were key drivers for integrating health and care services. Other acute services, such as elective surgical services, are not mandatorily included in this integration model, but mental health is.

Each local authority area must develop an 'integration scheme', setting out the scope of services to be integrated and their funding, and an integration strategy. Areas can choose to integrate additional services beyond the required minimum, such as children's health and social care. They can also choose whether to create their integration authority through a 'lead agency' approach (so that one organisation, either the NHS board or the local authority, takes responsibility for all health and social care aspects of a service) or by setting up an integration joint board (IJB) to which the NHS board and local authority both delegate the planning, governance and resourcing of existing responsibilities. Highland has a lead agency system, which predates the 2014 legislation, while the other 31 local authority areas of Scotland came together to establish 30 IJBs in shadow form during 2014/15 (Stirling and Clackmannanshire formed a joint IJB) which then assumed full powers from April 2016.

Local authority areas in Scotland vary significantly in population size, socioeconomic and geographical characteristics, population health and care needs, health and care service provision, and relationships between local health and care organisations. In addition, each is divided into multiple localities. It is at the local level that services integrate in practice, through re-designed pathways of care and bringing together management and staffing arrangements, with locality-specific prioritisation and community engagement.

The IJBs are statutory bodies that make decisions and manage public funds in their own right. Each has a chief officer who leads the approach to integration in their area, together with a chief finance officer and the IJB chair and members. The membership is broad: it includes councillors and NHS non-

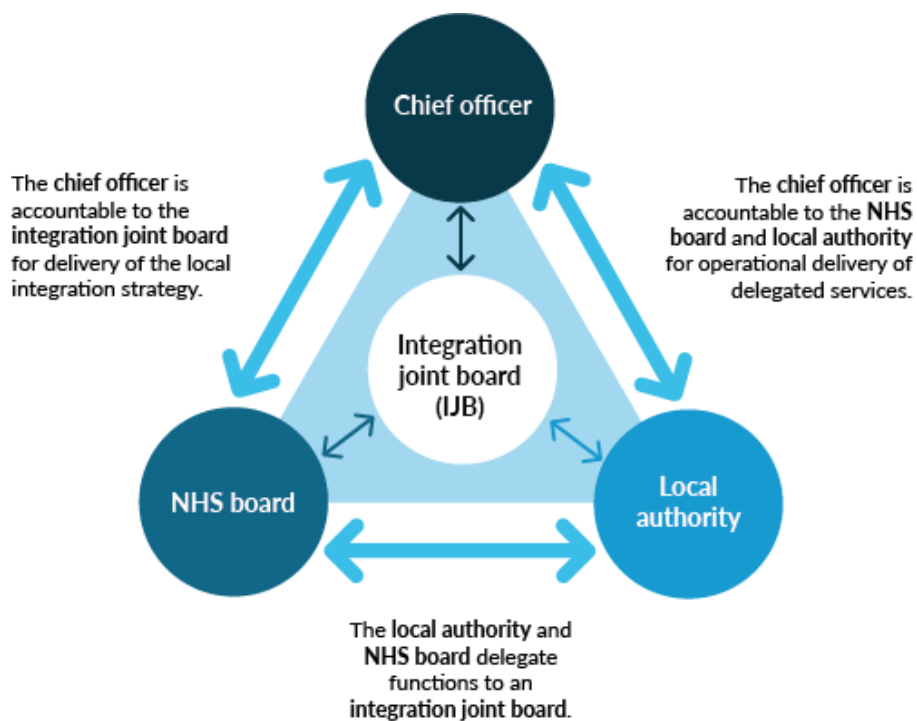
executives in all cases, plus other members (who do not have voting rights) who are professional and managerial representatives and community and staff stakeholders.

Each IJB receives delegated funds from the NHS board and local authority (there is no separate direct funding from the Scottish Government). The chief officer is accountable to the IJB for leading implementation of the integration strategy, including how planning, service development and allocation of funds support its objectives.

The IJBs do not employ staff: existing NHS board and local authority staff work differently in services that are integrating, rather than employing new staff. The chief officer is accountable to the NHS board and to the local authority as the operations lead for these services, overseeing their day-to-day performance and ensuring a framework of policies, standards, operational plans and governance to support their integration.

Chief officers therefore have two sets of accountabilities: to the IJB for strategic leadership, and to the NHS board and local authority (with membership of their corporate management teams) for operational leadership. These are illustrated in Figure 1, below. These accountabilities need to be aligned and while the chief officer role is still young, understanding of how they fit together is still developing.

Figure 1 Chief officers, NHS boards and local authorities' roles in areas that have IJBs



2 The chief officers' approach to integrating health and social care in Scotland

Rationale

The starting point for the chief officers' approach to integrated health and care, is that integration is both necessary and makes an important difference.

- Integration is not the goal in itself: the main objective is to improve health, wellbeing and quality of care. This is reflected in the nine national health and wellbeing outcomes for integration (see box below). Just as in the other UK countries, achieving these outcomes is frequently challenged by delays in accessing services when people need them; by resorting to admission to hospital rather than providing early or ongoing services in the community that would fit better with everyday life or prioritising prevention; by delays in being able to leave hospital with the right level of support; and by inequalities in health and in an individual's ability to manage their own health. Joining up services to organise them around individuals in an area, rather than designing them around institutions and expecting people to fit in, and promoting health and quality of life rather than just treatment and care, are increasingly recognised as key to improving these problems (Curry and Ham 2010).
- Integration is also necessary because if services are planned and delivered together, rather than each pursuing its own strategy independently, the resulting improved efficiency will help Scotland to manage the predicted increases in demand as people live for longer with multiple health conditions and ensure sustainable health and social care services. The closer co-ordination will also promote a shared understanding that can enable the fundamental changes in care models that will be necessary if they are to keep pace with people's changing needs (Ham and Alderwick 2015).

Scotland's national health and wellbeing outcomes

By working with individuals and local communities, integration authorities will support people to achieve the following outcomes.

- People are able to look after and improve their own health and wellbeing and live in good health for longer.
- People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- People who use health and social care services have positive experiences of those services, and have their dignity respected.
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- Health and social care services contribute to reducing health inequalities.
- People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
- People using health and social care services are safe from harm.
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
- Resources are used effectively and efficiently in the provision of health and social care services.

Source: Scottish Government 2015c

This is clearly reflected in legislation and policy in Scotland: integration of health and social care is a requirement, not an aspiration. It builds on the significant and consistent progress that Scotland has made toward joining up health and social care systems since devolution in 1997.

But previous approaches did not fully achieve their ambitions, with successes generally limited to localised examples rather than changing the system because they lacked the authority needed for fundamental change (Audit

Scotland 2015). By contrast, chief officers and integration authorities have a clear basis in law which requires that planning is joined up across NHS boards and local authorities. Chief officers and integration authorities also have resources: they control budgets currently totalling more than £8.5 billion (for context, the total NHS and adult social care budgets in Scotland are currently £13.2 billion and £3.1 billion respectively).

Integration authorities – through the IJBs and chief officers – have the authority to integrate care. However, if whole-system working is to be successful, they need to use it to develop collaboration and partnerships: integration authorities cannot make integration work on their own. When they bring partners together they can make things happen that would not otherwise be possible. An example of concrete – and innovative – action facilitated by an integration authority is a safe drug consumption facility for substance users to inject in a clean environment under supervision, and access other treatment and support services, now planned in Glasgow.

Chief officers lead the development of integrated services through engagement and actions at local level, so that approaches are tailored to local communities and circumstances, are seamless for service users and reduce health inequalities. This localism is fundamental to their role and approach, and is where people using services and staff who deliver them experience the reality of joined-up services. It is the basis for taking forward the Christie report emphasis on developing new relationships with communities, and the distributed, devolved leadership that it involves, is another feature that the approach has in common with social movements.

However, by acting as a national network as well as local leaders, chief officers can also co-ordinate their roles across Scotland's health and care system. Specifically, they have the potential to influence policy, ways of working between national bodies and social norms (in particular, expectations about how community and staff views will drive service development), so as to achieve systemic change towards integrating services at national level.

How chief officers are developing their approach

Although specific approaches vary according to each area's characteristics and needs, chief officers have been developing their role in three broad ways at both local and national levels.

- They are developing, with their partner organisations and with communities, a shared **vision and ambition** for joining up services to meet people's needs and promote health and wellbeing. They describe this ambition in terms of a social movement for integrating and improving health and social care.
- They are championing, through a range of approaches including constructive and disruptive challenge as well as encouragement, a quality of **mutual understanding and relationships** that can support effective and sustained delivery of integrated care across the health and care system.
- They embody and aim to model the **strategic leadership** needed to maintain a clear focus and to oversee the processes and relationships involved in transforming a highly complex system with energy and a commitment to high-quality, inclusive services.

These three key approaches are based on a clear understanding that the transformational change required for integrating health and social care is not just about creating structures, such as new organisations, or co-locating teams, but must always start from the best interests of communities and service users. It cannot be imposed top down but must be owned by the services involved and the communities that they serve, sharing many of the features of a social movement and empowering communities, staff and professional disciplines to shape local services (Ham 2017). As The King's Fund has reported in relation to Northern Ireland (Ham *et al* 2013), legislating to bring the NHS and social care together will not on its own overcome a long history of differences. The leadership required to make integration work, is particularly about creating the conditions for sharing and bringing together of different partner organisations' power, rather than exercising power one over another (Meates 2017).

Where the commitment to integration is reciprocated between chief officers and their partners, significant results can be achieved. Where it is not reciprocated and where historical boundaries of hierarchy and sectoral interests prevail, integration becomes more difficult. For example, we heard examples of local authorities and NHS boards under financial pressure, who had sought to achieve cost improvement targets unilaterally – even though this was likely to be at the expense of integration objectives – rather than seeking a conversation about how to manage a challenge affecting the entire local health and social care system.

The chief officers' approach involves striking a series of complex balances. These include: localism **and** national leadership, innovation **and** standardisation, setting overall vision **and** doing detailed co-production, supporting NHS ways of working **and** local authority ways of working, managing the challenge of service delivery today *and* progressing a broad future agenda (Ham 2014; Scottish Government 2010).

Looking at the Scottish approach to integration of health and social care through a 'systems' lens, the role of chief officer is significant in that it embodies and signals a shared intent for the whole system. The Scottish Government has chosen to embed this role, and accountability for leading integration, in named individuals who need to demonstrate capability and credibility in the task of negotiating integration as a system change ambition. Establishing IJBs and the requirement to agree financial settlements also signals an expectation of collective responsibility for facilitating integration. Integration is not the sole responsibility of the chief officers but is dependent on the relationship between chief officers and their system partners and the relationships between the leaders of the system agencies represented at the IJB.

The tension of bringing these multiple responsibilities together can be difficult to work with and is a source of frequent debate and frustration. Arguably this is the space that system leaders are required to work in (Workforce Scotland 2018; Timmins 2015). The tension will be felt by the other system partners as well as the chief officers and reaching a common understanding of this common experience will help in understanding the opportunities that can arise from pooling efforts to manage it and working together on a basis of trust.

What the approach looks like in practice

Locally, chief officers are contributing and catalysing energy, which is enabling a bottom-up approach to making integration happen. There is significant diversity of priorities, ways of describing and reporting on them and processes (such as governance arrangements). These reflect the differences between areas, and it is through this approach of building from a bespoke local vision that people buy into (rather than a single template, top-down requirements or a focus on structures) that the approach most resembles a social movement.

It is also noticeable that within this diversity, some areas are moving ahead faster than others and sometimes there are challenges in maintaining pace and momentum. It is hard to say how much of a problem this is, because the

diversity of approaches also means that it is difficult to measure progress in a comparative way: the scale of differences in progress is more of an impression than an empirical assessment. It does, however, appear that where progress slows or is effectively blocked by the various organisations involved in adopting different priorities, chief officers can be isolated by the experience and it can be personally demanding where they need to re-build commitment, as well as difficult to know how best to do so.

Developing and embedding relationships is a major part of the chief officers' role within their areas, and they are consciously seeking to model the leadership skills needed for this. Their approach is driven by the core principles and recommendations of the Christie review and involves mobilising a range of capabilities (see boxes on p 15 and p 17).

The Christie review

The review set out public sector values for today's Scotland:

- *Respect for the autonomy and potential of the people and communities of Scotland, and the ambition to help maximise both.*
- *The ambition to improve the lives and opportunities of the people and communities of Scotland, and a commitment to work with them to achieve their aspirations.*
- *A commitment to get maximum value and impact for public resources, and to account openly to the public for what is done in their name.*

These elements stand alongside the established principles and standards of public life, including integrity, honesty and openness and are the counterpart to what we believe to be a wider public service ethos.

In our view, it is essential to the future success of Scotland's public services that all stakeholders now work together in an urgent, sustained and coherent programme of reform of how Scotland delivers public services. Outcome-focussed transformation requires strong leadership, the resources of all stakeholders and a reasoned understanding of how outcomes are achieved.

Scottish Government 2011, paras 3.9 and 4.53

Chief officers' roles are still new and, although there is a recognition among them that a particular style of leadership is essential to the success of integrating services, we suspect that the leadership challenge is generally underestimated. Effective approaches are being learnt in real time, without any pre-existing infrastructure of norms, expectations or organisational memory to build on – in contrast to the long-established traditions, cultures and processes in NHS bodies, local authorities and professional groups, which may need to change and adapt to integration. Chief officers navigate multiple accountabilities, and influence change in organisations and individuals that may have their own priorities and can have differing levels of commitment to integration, at the same time as managing day-to-day operational pressures. While chief officers are widely perceived as embodying the integration

agenda, the integration leadership challenge extends to many others, including operational leads for individual services, leads in partner organisations and, collectively, the IJB.

There is an additional risk of an unintended consequence when the aspiration for a new system based on integration connects with the pre-existing system based on organisational accountabilities, hierarchies and assumptions about what leadership, professional identities and accountability look like in health and social care. The risk is that shared system responsibility gets projected on to the chief officers as individuals, rather than truly owned by the range of partners, and that the inevitable difficulties in making 'sufficient' progress on integration and influencing wider partners to collaborate on the shared system agenda become seen as reflections on the chief officers personally. It is our observation that chief officers are often either held personally to account or may personally have to shoulder the responsibility of trying to influence senior organisational leaders to act congruently with espoused system ambitions.

However, as Workforce Scotland (2018, p 3) makes clear:

There is recognition that no single organisation or agency will be able to tackle these [complex and intractable issues] alone, and that effective collaboration in support of transformed outcomes is difficult to achieve. This work is often complex, messy and unpredictable.

Building on previous analysis (The King's Fund 2012, 2011) and observations from our engagement with the chief officers, we identified a number of key elements in the leadership challenge for local integration of services in Scotland (see box, p 17).

Shared leadership: what capabilities do chief officers and, equally importantly, their local system partners need in order to lead integration of health and social care in Scotland?

- The ability to work constructively and collaboratively with the dilemma of shared priorities that may not align with individual, organisational or sectoral priorities, and to cede personal and organisational priorities for shared goals.
- The ability to adapt and use multiple leadership styles, such as leading together as peers from different organisations with system-wide roles, leading singly, and leading in selective partnerships
- The ability to delegate and let go of hierarchy, empowering leaders at different levels and especially at the front line.
- The ability to engage with complexity arising from interdependencies, uncertainty as situations emerge, giving up the need to control and 'fix' problems, and a depth of respect for partners which means that difference, multiple perspectives and lack of agreement will be worked through rather than overridden.
- The ability to re-frame reactive problem-solving so that it becomes co-creating the future with stakeholders.
- The ability to build legitimacy and influence through the quality of relationships (personal as well as positional authority).
- The ability to critically reflect on and engage with one's own thoughts and feelings in order to understand situations, dynamics and one's own role in them.
- The ability to work 'beneath the surface' to acknowledge and work with unconscious processes and unspoken relational dynamics.

Realising these capabilities will require ways of working which:

- commit to a shared purpose and partnership working
- value learning together from wherever knowledge exists (including feedback and insight from people who use health and care services) – not rushing to a solution or prioritising only performance management metrics

- focus on results: personal and collective accountability
- follow through espoused behaviours and principles into practice.

At national level, chief officers are playing an increasingly significant role in policy development. This aspect of their role was not fully appreciated at first: for example, the role of the chair of the chief officers' network was initially conceived in terms of chairing its meetings but it has evolved to also have a key role in managing relationships with national bodies and making connections so that chief officers' views are represented.

The new national GP contract is a powerful example of how, as integration authorities developed an increasingly important role in commissioning primary care services, it became essential for chief officers to be involved in the national negotiations, and to do so with an enabling, collaborative style. One chief officer needed to take a lead within the network, to develop agreed positions and to represent the chief officers collectively in national negotiations. This approach has also been developed in other areas, by chief officers leading communities of interest across the network.

As well as contributing to national policy development, the network of chief officers has identified the need to speak with one voice on other issues too – in particular, policy positions that other stakeholders may need to be aware of, and communicating success stories in order to reinforce momentum for integration. The implication is that the network will give chief officers a collective national identity and visibility, as well as a local profile. Until now, the network of chief officers has focused on sharing information and experience between its members, rather than promoting a national narrative on integration, but their development of 'communities of interest' for priority areas within the broad integration agenda, provides a direct, collaborative process for agreeing positions.

Examples

The following examples – by no means exhaustive – illustrate the range of collaborative developments under way.

Moderating demand for hospital care

Aberdeen has developed a multidisciplinary hospital discharge hub, with a workforce crossing both NHS and social care services, and a focus on supporting effective leadership. In winter 2017/18 it ensured both the capacity and capability were available to cover peaks in demand, including holiday closure periods. With a full complement of social workers, care managers and allied health professionals managed as a single team (regardless of employer), the team ensured rapid assessments and eased flow through the acute hospital to home or a homely setting.

In Aberdeenshire (a separate integration authority) virtual community wards provide short-term multidisciplinary support to avoid the need for hospital admission. A core team at GP practice level works flexibly (for example, any member can trigger extra support at short notice without needing formal referrals) and a face-to-face daily huddle reviews and makes decisions on care provided. More than 2,000 people who would otherwise have gone to hospital have received care at home. Better access to personal care and nursing are cited as the most important factors preventing hospital admission.

In both cases, these models of care are not new inventions, and the changes in day-to-day practice that they involve are small – they are about bringing staff roles together rather than radically re-conceptualising them. They are successful examples because of the ways in which staff have been able to come together seamlessly across the NHS and social care, or across primary and community health services and social care, without the obstacles of different organisations, budgets and systems which might have got in the way in the past. The emphasis on integration at the front line of care and removing obstacles to empower staff has also had a positive impact on staff morale and engagement.

Shifting resources to home care

In Glasgow, concerns about delayed transfers of care led to a new approach in which patients who were medically fit for discharge would be discharged within 72 hours, with rapid assessment and mobilisation of support rather than the historical situation of waiting in a hospital bed for assessment.

However, a significant number of patients were fit for discharge but not safe to have rapid assessment at home due to their personal care needs.

The IJB – still in its fledgling days at this time – was able to use its position across social care and the NHS to commission the services needed by this group. Its contracts with nursing homes specified a re-ablement approach and set targets for the throughput of people who would return home within 28 days. As the commissioner of primary and community health services, the IJB was also able to specify a model of in-reach by community health rehabilitation staff and to ensure extra capacity for GPs to work with nursing homes and carry out regular ward rounds and comprehensive assessments in the homes.

While integration is often described as leading to a shift in resourcing from hospital to community-based services, it can also be associated with a shift from residential care to care at home. In Glasgow, around 30 per cent of people who would previously have had a long-term placement in a care home or nursing home, are now able to return home after a short period of intermediate care. With further support to help people stay at home, including assistive technology, the health and social care partnership has reduced its use of private care homes and nursing homes in the city by a quarter in the past three years.

Changes at national system level

Negotiations for general medical services concluded in 2017 with a vote by GPs across the country to accept a fundamentally new contract. The Scottish Government described the contract as the most significant reform of primary care in more than a decade, designating GPs as 'expert medical generalists' and giving them clearer roles in overseeing care that will increasingly be delivered by a range of different professionals. Chief officers developed a role in the negotiations both in advising the Scottish Government about how integration authorities are developing their approach to commissioning primary care, and in directly participating in tri-partite meetings with Scottish Government and the British Medical Association. Their collaborative approach to the negotiations helped to create common purpose in delivering positive outcomes. These are set out in a national memorandum of understanding and mirrored in how integration authorities are working with NHS boards and local medical committees to implement the contract.

Re-designing care models through engagement

The chief officer for Angus has led a series of engagement events with staff, patients, members of the public and third sector partners to involve them in developing a new model for services. A multidisciplinary, multi-agency primary care team is now at the centre of The Angus Care Model, building on learning that already existed in multi-agency mental health and learning disability services. This is a fundamental re-balancing of the system, in which services previously had been arranged by organisation and hospitals had the central role. There is strong involvement of third sector organisations and of social care providers, especially nursing homes which are developing roles in step-down/step-up care and home care services which are much more than adjuncts to health care. The IJB is actively supporting workforce planning across social care providers (most of whom are independent) as well as NHS ones, and seeking to influence market development through its commissioning. The next phase of engagement is to involve people in re-shaping the distribution of inpatient beds and improving urgent care.

Improving wider determinants of health

Many examples of integrated health and social care concern ways of managing interfaces between services. But as partnerships become the embedded way of doing business, this can also lead to broader strategies for improving health and wellbeing and reducing inequality.

In Glasgow, the health and social care partnership took the lead in developing new services for homeless people to better meet their complex health and care needs, because it recognised that housing is a key determinant of health and wellbeing. The combination of a government report encouraging a 'housing first' policy (ie, providing housing first to ensure stability while addressing other needs, rather than providing housing after other needs had been met) and the city council's need to re-provide hostel accommodation which would not be able to stay open in a regeneration zone created an opportunity.

The health and social care partnership used its partnerships across organisations within and beyond the NHS and social care sectors, the broad membership of its IJB (including local councillors) and its links into the Scottish Government to secure agreement and discuss funding of an initiative. Now the partnership is on track to provide housing, together with social care support and access to health care, for 55 homeless people, within six months of starting this process.

Developing shared purpose across staff in different sectors

An inspection of services for young adults with autism and challenging behaviour prompted re-consideration of the inpatient service model in Moray. In particular, the health and social care partnership brought different professional groups together to discuss their assumptions about managing risk, which were sometimes fundamentally different, and engaged service users and carers in understanding what best-quality care should look like.

As a result, the inpatient service (including out-of-area placements to specialised facilities) has been replaced by tenancies in new-build housing supported by highly personalised packages of care. As indicators of improved care, incidents, especially severe incidents, and use of 'PRN' medication (medication prescribed but only to be used in certain situations when necessary) have fallen by almost three-quarters, while injuries to staff and restraint of service users have become exceptionally rare.

The chief officer for the area told us that the change was not based on better understanding of clinical evidence, so much as a process of discussion that empowered staff and service users to develop a shared sense of what was possible, keeping a clear focus even when there were challenges, and the ability to re-plan a single budget which had previously been fragmented.

Targeting support to people with complex needs

The IJB in Fife has developed an approach for community health, social care and GP services to use a set of indicators from existing information sets, plus clinical intelligence and judgement, to identify people at risk of heavy or increasing use of health services. The services are resourced and organised to provide additional support to these individuals to achieve 'high health gain' by keeping them well and at home, reducing their need for hospitalisation.

This targeted approach is driven by comprehensive assessment of the person's physical, mental and social needs, including anticipatory planning in case of change or deterioration. A single health professional – a district nurse – acts as case manager and care navigator, to ensure that services join up around a person's needs. The district nurse has direct access to a range of services, thereby avoiding historical issues of referral processes and criteria, and attends regular huddles of the full multidisciplinary team at which cases are reviewed and decisions made about care. More than 130 people have benefited from this service so far, including examples of care that have led to radical reductions in hospital use.

Community engagement

South Lanarkshire has developed a community engagement framework that sits at the centre of how services are being re-designed so that they work more closely together.

The framework has a set of guiding principles, a range of methods and approaches for different situations, and links to a national database of tools. It is seen as supporting a long-term approach that will develop over time and a strategic direction for sustained culture change, rather than a template or quick 'solution' for better community engagement. Working with the University of West Scotland, the health and social care partnership intends to measure over time the capacity that is freed up and the service use that is prevented through use of the framework to engage people in staying well, and assess its impact in building up social capital.

Developing primary care in integrated approaches

GPs in Scotland co-ordinate across local 'clusters' of practices to share learning and spread good practice. In Fife, the IJB extended this approach to support some clusters not only for quality improvement initiatives between GP practices, but also with other health and care partners. This has included developing GP and nurse practitioner input to care homes to ensure access to treatment outside hospital, continuity of care, regular assessment and development of care home staff roles. Work with social care colleagues to develop social prescribing and other non-medicalised support for wellbeing, such as mindfulness classes, is a notable feature.

GPs in Scotland are under significant pressure but empowering and supporting them to define and develop good practice for their specific community of patients has improved morale. By rooting this work in GPs' own existing networks, and involving local medical committees, the 'early adopter' GPs are promoting new roles in joined-up care to their peers. This is work in progress and expected to develop over time. It reflects an approach of enabling and supporting, rather than top-down direction, and allowing for potentially significant local variation within a broad strategic direction.

Shifting resources from hospitals to community

In South Lanarkshire, the health and social care partnership – led by the chief officer – worked with acute colleagues to close a community hospital ward and re-provide the care by establishing more community-based services. These included integrated care teams in local communities as well as step-down beds in local care homes. This resulted in a more effective service with a reduced number of hand-offs of care and increasing numbers of people discharged from hospital wards directly to home.

The partnership led the joint development of a detailed business case underpinned by a model for calculating and apportioning costs. This model in turn built further confidence, resulting in a mature negotiation, mutual trust and an agreed formula for re-allocating funds between the NHS board and the health and social care partnership.

3 Next stages of implementing the chief officers' approach

Building on progress

All 31 integration authorities can share examples in which not only have services been transformed, but the process and experience of partner organisations working together have been radically different and better than that in the past. But integrating services is still work in progress and is uneven: in areas without long-established relationships and histories of joint working, progress has sometimes slowed or stopped if key partners disengage to focus only on their internal priorities. A report by Audit Scotland (expected in November 2018) will provide an important assessment of integration authorities' progress and impact.

Local actions: what next?

Audit Scotland (2015) has described the complexity of the relationships between integration authorities, NHS boards and local authorities. Eighteen months later, these relationships continue to be complex because there are multiple lines of accountability, different performance and finance priorities in each partner and decisions by partner organisations are inter-dependent. These complex relationships are unique to the Scottish situation (see the appendix for a discussion of similarities and differences between the integration agendas in Scotland and England). For example, voting members of IJBs are drawn from NHS boards and local authorities – the very organisations which may be perceived as benefiting or losing territory by IJB decisions. In order to achieve its objectives for integration, an IJB may want to challenge an NHS board or local authority to change its practice; but in doing so, it must also bear in mind that it is ultimately dependent on these two organisations for agreeing how much funding is delegated to it. And chief officers may want to influence local NHS or local authority leaders, but at the same time they must work well with them as a member of their corporate management teams and with management accountability to both chief executives.

Some chief officers have described a sense of confusion over which was their 'home team', which could result in feeling like an outsider in both the NHS board and local authority senior leadership teams. Chief officers and, importantly, their partners need to reach a shared understanding of how they relate to each other, so that chief officers' role in leading change can be based on agreed legitimacy and the trust that comes from local partners following a single plan. This may need to be considered in each area individually, given differences in approaches and of history, and because it is more of a concern in some areas than in others. But there is also a need for greater national clarity about expectations on all the partner organisations about the scale and pace of integration. While recognising that there is very little spare capacity, nonetheless ways for chief officers and integration authorities to provide more peer support to those areas making less progress need to be identified – there are already examples where this has happened that could be built upon.

The 'set aside' budgets are a particular example where, despite guidance (Scottish Government 2015a), relationships sometimes made progress difficult. These budgets cover IJBs' share of the funding for acute hospital services, reflecting those services that are delegated to them. It is notoriously difficult to disentangle hospital budgets, as services may be inter-dependent and have shared elements, and the Scottish Parliament's Health and Sport Committee (2017) has also noted operational difficulties of bringing delegated budgets together and ensuring a depth of integration in planning across them, for example, because NHS and local authority financial cycles work to different timetables. But the biggest difficulties have been when NHS boards have continued to treat the delegated budgets as if they were theirs. The policy intent on these budgets is clear and they are designed to lead to a fundamental change in how services are conceived – not rooting them exclusively in traditional hospital settings – and result in a shift of resources and activity to community-based services. But ways need to be found to ensure that this is followed through. Evidence from New Zealand suggests that when commissioners are able to broker contracts for services that balance individual organisations' interests **and** the needs of the local community **and** the local health economy's shared vision, it can help create a tipping point for really embedding partnership working (Charles 2017).

These complexities of relationships are not inherent to integration, and it is often more likely that they will have their roots in the local area's history of services, individuals' styles and beliefs, and choices that are made about how organisations work together (for example, in establishing relationships). They

may therefore improve over time, but there are no easy solutions or quick fixes (Timmins 2015).

Although influencing through relationships can be hard work, the chief officers are well placed to make progress on this. There is evidence that for changes which diverge from practice that has become deeply established and perceived as the only way of doing things, change agents are most effective when they are one step removed from the owners of that practice and when they adopt approaches of social influence rather than heroically generating solutions (Battilana and Casciaro 2012).

Each area has different circumstances and different starting points and strategies for integrating services. However, there are also some issues that are priorities across most or all areas.

- The need to focus not only on improving treatment and care services, but also to ensure strong action on population health improvement, including prevention of ill health or loss of independence and reduction in inequalities, through partnerships which will increasingly go beyond NHS and social care services.
- Ensuring good-quality engagement with communities, patients and third sector partners as plans develop and services start to work more closely together.
- Maximising use of technology, including interoperable information systems and information sharing, and equipment to promote safety and efficiency.
- The need to embed and develop improvements in managing unscheduled care, including preventing avoidable hospital admission and supporting the ways in which the interfaces between primary care, community services, social care and hospitals work together.
- Ensuring that the workforce implications of new ways of working in partnership and new pathways of care (such as training, recruitment and definition of new roles) are fully planned for and managed, and staff and professional bodies are fully engaged.
- Streamlining and reducing bureaucracy for governance and public assurance.

These priorities will involve developing work that has started and increasing its scope and ambition – ‘moving up a gear’ – or ensuring that work has

started across a broad range of areas (not just delayed transfers of care and unscheduled hospital admissions). However, as noted above, there is currently a lack of clarity between partner organisations about what the pace and scale of integration should be and how to support areas not achieving that pace or scale.

National actions: what next?

The network of chief officers was established as a peer group to 'exchange valuable information and to discuss common challenges as integration arrangements progress' (Scottish Government 2017). Increasingly, the network has also started to develop a defined programme of work to establish common approaches in priority areas, and to co-ordinate input to national policy processes. This reflects an increasing understanding of the role, its importance in the wider health and social care system, and the need for chief officers to participate in national policy and strategic agendas.

Chief officers have established and led communities of interest to develop common positions, share learning and represent the network on the following priority areas:

- 21st century approaches to health and social care, including effective capital investments, evidence-based commissioning, maximising use of technology, ensuring demand is sustainable and the six challenges for 'realistic medicine and care' laid down by Scotland's Chief Medical Officer (Scottish Government 2016)
- mental health and wellbeing, with a positive asset approach
- local-level integration with increased roles for multidisciplinary primary and community health services and new ways for them to work more closely with social care providers and hospitals
- oversight of the workforce, including recruitment, retention and workforce planning, skill-mix, new roles and use of volunteers
- public assurance, for example, on use of resources and inspection of quality of care.

Input to policy processes has particularly involved engagement with Scottish Government ministers and officials, the leadership of the NHS and NHS boards, and local authorities and their chief executives. This has required arrangements to authorise chief officers to speak on behalf of the network, which has, in turn, often required agreement of a common position, and to

facilitate this, the network is now supported by a policy manager. These initial arrangements will need to be strengthened to develop the network's engagement with other national stakeholders. At present, engagement can sometimes fall to a small handful of chief officers, in the absence of other chief officers having defined leadership roles for areas of policy, and positions may need to be developed at short notice, without the ability to fully reflect the diversity of experience across the chief officers. The network of chief officers may need to be clear with national bodies, such as the Scottish Government, about how to engage with them – for example, how much notice they need and, in particular, who to engage with on what – and they may need to use these contacts purposefully to raise awareness of achievements.

Chief officers will increasingly need to help design national processes, such as performance monitoring and financial controls, as and when they require adaptation to fit with changes arising from greater service integration locally. This national role is still at a relatively early stage and the importance of chief officers' input to national developments is likely to grow rather than reduce. Chief officers need to have the capacity for carrying this out, but this needs to be balanced against the need to also keep sufficient capacity to drive integration at local level. Similarly, arrangements need to be in place to enable the network to speak with one voice at national level, but without underplaying the diversity of experiences and roles, which are a strength in the chief officers' approach of localism.

The network of chief officers has identified a need to define more formally what its future programme of work should be and how to make it visible externally in order to engage others. There needs to be balance, so that there is sufficient structure to be efficient and effective, but avoiding the creation of a formal organisation and layers of bureaucracy. Resources are currently being put in place to manage this through ad hoc arrangements for each integration authority to contribute a proportion of funds, and this informal process may need to be kept under review as the work programme develops.

As part of the future work programme, the network needs to consider external communications. There is a need to actively promote information about the integration authorities' achievements to help build momentum. In addition, some issues need national debate (for example, to build understanding of the different ability of an integrated system to manage risk, compared to a single organisation); and steps may be needed to ensure a visible profile for the chief officers and the network. A consistent, clear brand, that avoids the jargon of legislation and structures, may be useful.

A more formal work programme may prompt greater definition of lead roles among network members. Volunteering to take a lead may increase accountability for delivery, and the network needs to consider the degree of assurance that it needs (without creating undue bureaucracy), so that when discussions take place with the Scottish Government and other national bodies, it is speaking with one voice in line with agreed objectives. Over time there may need to be further consideration of what is involved in chairing the network (it has become clear that it involves much more than just chairing meetings).

The network needs to enable chief officers to engage in national processes in the same way that chief executives of NHS boards and local authorities do and with an equivalent status. This is not to advocate creating a formal representative organisation, and it must not distract from focusing on local progress, as that is where integrated services are delivered in practice. The fact that chief officers are already being invited to national policy forums suggests that the need to engage them is recognised, there is a will and means to do so, and what the network can add beyond that is to ensure thought-through, consistent input combined with an ability to oversee how national policy development translates into local action. That will require further development of processes and how chief officers' roles fit together within the network.

Developing and communicating these capabilities should be matched by an openness to engaging with other national bodies – for example, as professional organisations develop guidelines for their members, as health and care improvement agencies and regulators develop their approaches, or as other parts of the public sector, such as the public health system, are reformed. The aim is that, increasingly, national bodies should seek out the network as a stakeholder that enables them to engage all the chief officers in one go, and the network will engage with a wider range of partners in addition to NHS boards, local authorities and the Scottish Government. That will strengthen and further embed the integration agenda at national and strategic levels.

The changing environment

The policy environment in Scotland for health and social care is fast-moving: every time the chief officers came together with The King's Fund, there were new policy developments needing attention and new priorities that had come to the fore. The chief officers' roles need to retain sufficient flexibility and

dynamism to engage with, respond to and play a leading role in developments that will emerge from time to time in the wider national agenda for health and social care and the Scottish Government.

The current development of a regional planning process for health services based on dividing Scotland into three regions is an example of how changes in the wider policy environment impact on chief officers. Their experience of engaging with it seems to vary. Some told us they had constructive, positive engagement. Others were concerned that it might dilute focus from integration and result in effort being diverted back towards previous (sectorised) ways of working, given that the regional plans are NHS specific. Overall, there were varying levels of involvement in the shaping of strategic plans for the NHS that this process involves. It illustrates the need for chief officers to strike a balance between their own (local and national) agendas, and also helping to shape the strategic direction of the wider health and care system. Given the importance of chief officers' roles in the health and social care system, they cannot be neutral bystanders: the network could do more to clarify whether regional plans are a priority and, if so, how to maximise their collective input.

Although it is not possible to predict the changes that will take place, it is inevitable that chief officers will need to ensure capacity and processes to engage collectively as well as individually in areas such as:

- public sector reform and developments arising from the national clinical strategy, eg, development of public health systems
- public, media and political interest in service changes and reconfigurations
- Brexit and potential challenges to workforce supply
- continuing austerity and the need for difficult funding choices
- changing public and staff expectations, including potential differences between generations
- opportunities and risks that can emerge within a short time-frame from new technology and information systems.

4 Conclusions

The shared ambition for the network of chief officers

At local level, the shared ambition of the chief officers is to fully leverage their authority to lead transformational change that integrates health and social care for their local communities, through both their strategic role with the IJB and their operational role with the NHS board and local authority. There are two developments that will particularly assist this.

- Progressing the way in which integration authorities use their control of budgets to commission integrated services, so that all funding is aligned towards the local system's objectives for integration, particularly at locality level within each area. How funding shifts from 'traditional' medical and social care approaches towards new models of care and health promotion will be a key indicator of development with integration (including in particular greater clarity over how 'set aside' budgets are managed across hospital services). It will demonstrate the chief officers' and IJBs' ability to use the powers at their disposal to make change happen and 'move up a gear'.
- Developing peer support to ensure that progress is being made in all areas of the country, avoiding the potential risk of an increasingly widening gap between those areas making most progress and those making least. Given the big differences between areas, and differences of approach to integration, this may require further thought to be given to how to measure progress and how to transfer learning, but this does not need to be too formal. In our engagement with them, the chief officers had skills in using 'peer consulting' approaches to provide each other with practical support and to surface and work through systemic issues that affect them collectively.

Both of these developments fundamentally require leadership capabilities in chief officers and their partners that support working with complex systemic change across policy, service delivery, partnerships and public engagement. The Christie review offers important principles and an overview of public sector leadership and its connections to citizens and communities, but much of the practice of making integrated services a reality is still new and uncharted territory. It will be important not to underestimate this challenge and to maintain a focus on understanding and developing the personal and

collective leadership capabilities for chief officers after The King's Fund's engagement with them has ended. The leadership demand should also not be conceived as only being an issue for chief officers. IJBs are new and so are the operational leadership teams that work across organisations: there is a need to understand their leadership roles and development needs too. This will help to move away from the perceived heroic emphasis on leadership of integration as a senior leader responsibility and will facilitate a more sustainable, shared responsibility for change across the wider system. It may also facilitate a shift in the burden of responsibility for a system-change ambition so that there is consistently a shared ambition for change at all levels of Scottish public and civic sectors rather than one that is, at present, sometimes shouldered by chief officers alone.

Although this report specifically focuses on the role of chief officers, it is important to emphasise the critical importance of shared leadership responsibility for health and social care integration across the NHS, local government and community sector leadership systems. There is a particular challenge for leaders of NHS bodies and local authorities to understand how – depending on whether they can be aligned – their organisational and sectoral agendas can either facilitate or disable the integration agenda, and to consciously use the influence and power that their organisations have in the health and social care system. Both obstacles and opportunities for integration are created by the interaction between these different agendas: they arise from how the partners work together as a system, rather than simply as a consequence of the chief officers' work in isolation.

This shared ambition is mirrored at national level in the network of chief officers, and the key strategic steps needed at that level.

- The network needs a strong voice and role in national policy, so that the integration authorities' ability to make change happen is fully reflected and supported in national developments. This will lead to the network routinely being part of decision-making processes and a key stakeholder that national bodies engage with when policy impacts on local services. Within this, we highlight two issues.
 - Being part of national policy discussions will be particularly important in clarifying and agreeing what the scale and pace of change should be and ensuring arrangements to achieve it in all areas. It is likely that without national discussions to agree expectations on scale and pace, involving chief officers and other

system leaders, there will continue to be differences of view at local level and difficulties in articulating how the many local initiatives add up to national progress. This is because – as we have described elsewhere (Ham and Walsh 2013) – a narrative and vision that is shared by **all** the key partners and can be translated into delivery plans at local level will help to ensure that integration becomes a reality. At present, it is not always clear how the different progress being made in each area adds up to an overall national narrative of change and improvement, although an Audit Scotland review due later this year may help to clarify that.

- The need to have clear expectations and consistently aligned incentives and requirements that support them is causing chief officers to increase their focus on national level engagement, which is positive but must not crowd out capacity for progress at local level or use up capacity that is needed to support progress in all local areas. This risk can be mitigated by chief officers agreeing with national bodies how best to engage them (ie, making it as easy, effective and time efficient as possible) and spreading roles and responsibilities among the chief officers' collective capacity.
- The network should reach a position whereby it operates alongside the national groups of chief executives of NHS boards and local authorities, with equivalent status, as the three key strategic players who will make integration work. Increasingly, there will be a need to bring together the discussions that senior leaders in the NHS, local authorities and integration authorities have, both between themselves and in how they work with the Scottish Government and the public. The regional planning process, which divides Scotland into three regions, is an example where the chief officers' role will need to work alongside that of NHS and local authority leaders. The ministerial strategic group for health and community care is an example of how this can work.

Realising this shared ambition requires chief officers individually and collectively to carry significant responsibility and to make an ongoing commitment. Individually and through their network, it will be important to ensure that they are appropriately supported so that they do not 'burn out' but continue to develop. The Scottish Government should keep a watching brief to consider what further support, guidance, resource and processes, or even legislation, could be developed, updated or strengthened to help enable chief officers to achieve their shared ambition.

Ministerial strategic group for health and community care

This high-profile national decision-making policy committee was originally formed in 2008 to lead transformation of health and community care in Scotland. It is chaired jointly by the Cabinet Secretary for Health and Sport and the health and wellbeing lead in the Convention of Scottish Local Authorities (COSLA).

With the new legislation to establish integration authorities, it has widened its remit to focus particularly on progress towards the nine national outcomes for health and wellbeing. Its membership now includes a representative of the chief officers alongside the other national leaders, recognising their importance to the policy discussions and decisions.

Recommendations

Making recommendations on how to progress integration in Scotland is not the main purpose of this report. However, we suggest six areas that the chief officers and the Scottish Government's policy leads for integration of health and social care may want to consider for action.

The **chief officers** should consider undertaking the following.

- Further strengthen the work and role of the chief officers' network as a system leadership group. This should include strengthening of both internal and external-facing functions. For example, internally: continue to develop ways of organising the network to ensure it is sustainable and can achieve maximum impact for the chief officers' collective system leadership role as well as providing a sensemaking and support function in relation to their individual local leadership role. In this respect it will be important to:
 - ensure that the future programme of work for their network is sufficiently structured (but without creating bureaucracy), distributed across network members and supported by resources and a communications plan so that it clearly demonstrates progress against priorities

- ensure provision for individual and collective leadership development; ensure protected space for reflection and sensemaking about learning that emerges from their work to lead change through integration and find ways to continuously review and communicate systemic learning.
- Within the communications plan, articulate how the many diverse local initiatives add up to a national approach and national progress (for example, on the Scottish Government's integration outcomes) and how to disseminate learning and good practice.
- Share and clarify approaches to assessing local progress so that, despite the differences between areas, progress can be assured and they can demonstrate how they further develop and embed their social movement approach ('moving up a gear' with integration plans) and those areas making less progress can be supported by the ones making most.
- Develop an engagement plan so that the network can contribute to developments in, and be consulted by, other national bodies.

The **chief officers and Scottish Government** should consider the following.

- How to involve chief officers as core members of national networks along with NHS, local authority and Scottish Government leaders, so that their role in developing and delivering national policies is fully reflected where appropriate.
- The extent to which the leadership 'ask' for integration is understood and what might support effective leadership of system change in order to achieve national policy objectives and outcomes across the health and care system. In particular, the steps that might help ensure that chief officers, IJBs and cross-agency leadership teams can effectively carry out their role and not 'burn out' or 'drift'. This offer could range from personal support and development through to further strengthening of policy, guidance or legislation.

5 Appendix: Comparing experience in Scotland and England

There are many similarities between integration authorities and sustainability and transformation partnerships (STPs), but also significant differences.

Similarities

Both countries share a consistent view of the challenge that is faced from growing demand for health and social care and the need to fundamentally change health services to reflect changing (as well as growing) needs. Their common diagnosis is that services need to be better integrated. Both STPs and integration authorities are layering integration plans on to existing services and aim to get those services to work differently, rather than starting from structural change. Both have few, if any, staff (neither currently has budget or arrangements for directly employing staff). Both operate at sub-regional levels and are able to develop local approaches rather than working to a national template.

Both have found that establishing effective, practicable governance and structures to support joint working across the various organisations involved is complex, and this is work in progress (rather than completed) in both countries. In part, this is because it simply is complex to establish workable governance arrangements that are not too bureaucratic, across different organisations that each have existing accountabilities and work programmes. In addition, it is also because being able to deliver integration is contingent on relationships, but this aspect plays out differently in the two countries. In Scotland, chief officers, NHS chief executives and local authority chief executives operate in a complex situation in which chief officers have control over significant, but not all, aspects of service planning, funding and delivery, and while championing change with these partners they are also accountable to them and dependent on both to agree an integration scheme that delegates funds. In England, arrangements are developing without any blueprint or defined roles, and so need to be negotiated from a blank page. Both situations have the positive feature of flexibility to develop local

approaches. In England, there is also the disadvantage of the sheer amount of negotiation needed in such an uncertain situation. In Scotland, although the chief officers have a clear remit to lead integration in principle (and, through IJBs, clear powers), in reality they do not have full authority to do so unless this is negotiated with system partners (who may need to share or give up some of their leadership role).

In both countries, relationships between the various organisations are varied, with examples of some longstanding, embedded partnerships and other examples where organisations are at early stages of working together and find it difficult to agree approaches and follow through to deliver changes. In both countries, it has been difficult to manage assumptions and expectations about pace and scale and both have faced criticism at times for over-promising, under-delivering or insufficiently detailed planning (although there are also examples from both countries of rapid and significant improvements in the performance of some services and people's experiences of them).

The King's Fund has carried out extensive analysis of STPs (see Ham *et al* 2017, Alderwick *et al* 2016 and the blogs, articles and presentations in the STPs section of The King's Fund's website) and worked directly with many areas developing and implementing STPs and the integrated care systems (ICSs), which are increasingly seen as the next stage of evolution of STPs. Many of the challenges that STPs have experienced, also apply to the integration process in Scotland. For example, it is often not easy to articulate an endgame that partners can sign up to, as many aspects need to emerge from a process of engagement and negotiation. Where relationships are not yet mature, it takes time to develop them and this process cannot be rushed. It also takes significant time (years) to embed cultural change. Engaging frontline staff is essential not only for planning changes but also for understanding how and why services have developed over the years, rather than rushing to assumptions about resistance to change, but this is difficult and time consuming. National bodies have provided significant support for locally determined approaches but have also been experienced as interfering. With the initial priorities tending to focus on hospital services, some partners, such as GPs and social care providers, have not always been adequately involved initially and can then require significant effort to engage. The priority placed on involving service users and communities is often not matched by capability and knowledge about how to do so and, above all, how to use their feedback and derive insight from it to consistently drive service development.

Differences

In Scotland, the current approach to integration has been developed between 2011 and 2014, with engagement and parliamentary debate leading to an articulation of the approach. That approach is now set in legislation and seen as a flagship government policy. Following the legislation there was a shadow year before integration authorities were required to have everything in place and to assume their full responsibilities. In England, by contrast, STPs were clearly developed as a 'workaround' to the existing legislation (for example, managerial rather than statutory processes have been put in place to ensure collective accountability for control totals across STPs). Defining and developing integration policy has been led by NHS England more than parliament or the Department of Health and Social Care. Policy on STPs was established at short notice without any prior engagement and there was criticism over the lack of time for engaging local communities, frontline NHS staff and local authorities in local STPs (Alderwick *et al* 2016). STPs have currently been through two iterations (from plans to partnerships) and are expected to evolve further into ICSs (although the pace for that is uncertain).

There are potential benefits from England's rapid, flexible and evolutionary approach but, in addition to the uncertainty it causes, there are also significant risks (two applications are currently before the courts for judicial review of specific contractual issues related to integrated care and, in a few areas, local authorities continue to withhold support from their local STP). The legislative approach in Scotland has advantages of clarity and engagement, but there is also the potential for a lack of flexibility. There are perceptions in some quarters that it can be used equally as an enabler (legitimising the case of those advocating changes) or as a blocker (enabling those advocating against changes to reduce debate to the letter rather than the spirit of the law).

Infrastructure and policy around the STPs, such as performance management frameworks, have developed in England through a series of stages, each of which has had gaps or areas with little detail until the next stage of development has addressed them. In Scotland, detailed legislation has provided for the membership and function of IJBs, there are detailed integration schemes (ie, agreements between the NHS board, local authority and IJB) and there are national indicators for monitoring progress. In England, a Better Care Fund has been created which pools an estimated £5–6 billion per year (National Audit Office 2017) out of total English NHS and adult social care budgets of approximately £124 billion and £17 billion respectively

(general powers for pooling budgets also exist, which can be used on a case-by-case basis for individual services). Scottish legislation requires delegation of a far larger proportion – approximately half – of the total national health and adult social care budgets to integration authorities, making them the single commissioner for integrated services in their area. (The Scottish Government has adopted an approach of an additional fund for integration in the past, with some similarities to the Better Care Fund, but found that over time it was difficult to ensure that it would not be used to support or expand existing services rather than to create new, integrated ones.)

Although many clinical commissioning groups (CCGs) are merging or aligning their approaches, in many STPs there are multiple NHS commissioners (often with different approaches and contracts) for services that are being integrated. Both countries have different challenges of co-terminosity: in Scotland, the 14 NHS boards map to 31 local authority areas, meaning that one NHS board may work with two or more integration authorities, whereas in England the 44 STP ‘footprints’ often do not correspond to local authority areas or catchment areas of NHS bodies, meaning that NHS trusts, commissioners and councils may work with more than one STP, or STPs may have more than one of each type of partner. Local authorities in England can be at unitary, county, district or borough levels (many STPs include multiple levels), or devolved areas, with or without directly elected mayors, whereas in Scotland all local authorities are unitary, making a single framework for integration simpler. Similarly, in England primary care may be commissioned by CCGs or by NHS England, whereas in Scotland a single approach to integration is simpler as primary care is all planned and funded through integration authorities.

Implications

In general, the differences mean that there may be difficulty in translating learning between England and Scotland about the specific mechanics and processes of integrating services. However, the two countries are clearly addressing very similar issues – none of which has a simple answer – in relation to:

- the overall integration journey, as it increasingly broadens from an initial focus on unscheduled hospital admissions and delayed transfers to become a much wider set of priorities and partners
- the need to develop approaches that may be unique to each area, depending on what works for them, for underpinning ‘enablers’ such as

relationships, governance, community involvement, public assurance, communicating the case for change

- the relationship between localism and national agendas, and how to manage the implications of the variability of approaches which will be inevitable when localism is encouraged (for example, in how to measure performance consistently, or how to evaluate and spread good practice)
- understanding how to get the most useful balance of flexibility and clear legal requirements, to encourage creativity, responsiveness and innovation, but still have a coherent national approach with sufficient structure to support rapid progress.

The need to develop effective relationships between health and social care partners and local change agents stands out as a common theme across both countries, but is also an area in which the two countries have different types of complexity. As well as being simultaneously both a similarity and a difference, it is also probably the least defined theme that we identify and so potentially each area will need to reach its own understanding and methods of making the partnerships work.

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