Paper no: MSGHCC/105/2018 **Meeting date: 20 June 2018** **Agenda item:** 4

Purpose: **FOR DECISION**

Title:	**Reviewing progress on integration**

Key Issues:	At the health debate in Parliament on 2 May, the Cabinet Secretary undertook that a review of progress by Integration Authorities would be taken forward with the Ministerial Strategic Group for Health and Community Care, and that outputs arising from any further action arising from such a review would be shared with the Health and Sport Committee of the Scottish Parliament. This paper: a) provides an update on the work already underway, or committed to, to understand progress and to address challenges and to capitalise on opportunities for making a success of integration; b) offers a short analysis of key risks to integration, attached at Annex A, which need to be addressed in order for this programme of reform to deliver fully on its ambitions; and c) shares with the Group some information, attached at Annex B, on further work currently under development to support next steps.

Action Required:	For members to note; to consider whether further activity is required; and to consider the proposal made for next steps to be taken forward via a small group of senior officers chaired by Paul Gray (Director General Health and Social Care and Chief Executive of NHS Scotland) and Sally Loudon (Chief Executive of COSLA).

Authors: John Wood, COSLA Alison Taylor, Integration Division, SG

REVIEWING PROGRESS WITH INTEGRATION

Background

1. At the health debate in Parliament on 2 May, the Cabinet Secretary undertook that a review of progress by Integration Authorities would be taken forward with the Ministerial Strategic Group for Health and Community Care, and that outputs arising from any further action arising from such a review would be shared with the Health and Sport Committee of the Scottish Parliament.

Purpose

2. This paper:

d) provides an update on the work already underway, or committed to, to understand progress and to address challenges and to capitalise on opportunities for making a success of integration;
e) offers a short analysis of key risks to integration, attached at Annex A, which need to be addressed in order for this programme of reform to deliver fully on its ambitions; and
f) shares with the Group some information, attached at Annex B, on further work currently under development to support next steps.

Review work underway and committed

3. Officials from the Scottish Government, the NHS, local government and Integration Authorities are currently taking forward a number of workstreams to help address recognised challenges with implementing integration:

i. The Scottish Government's Director General for Health and Social Care and the Chief Executive of COSLA are chairing a sequence of cross-sectoral discussions with a fairly large group of senior colleagues from the NHS and local government. The focus is on reviewing progress on embedding integrated governance and leadership and considering further necessary action to support implementation. The next of these discussions will take place in late June, where attendees will be asked to agree a collaborative statement on delivering integration and an action plan to support delivery. The draft collaborative statement and action plan are attached at Annex B.

ii. The Scottish Government's Director for Health Finance has established and chairs an Integrated Finance Development Group whose members are drawn from the NHS, local government, Integration Authorities, Audit Scotland, CIPFA and the Scottish Government. The Group meets regularly and is working through practical questions relating to the effective management of integrated budgets, including arrangements for "set aside" hospital budgets. More widely, officials are working on plans to bring together finance leads from all the statutory agencies for a collaborative development

session later in the year. In the short term, a consolidated financial report covering all Integration Authorities has been developed in liaison with Integration Authorities' Chief Finance Officers. This consolidated report has been shared with the Health and Sport Committee, addressing previously identified issues of transparency arising from financial reports being published separately in each partnership area.

iii. Chief Officers of Integration Joint Boards are working with SG officials to develop updated and more detailed guidance on the use of directions. This will be an important addition to the suite of statutory guidance already published to support integration as it will help to address many of the issues described to us by local systems as causing confusion with respect to governance arrangements.

iv. Development work is underway with Chairs, Vice Chairs, Chief Officers and Chief Finance Officers of Integration Joint Boards to ensure they are implementing integration effectively and that their focus is on delivering better and more sustainable outcomes, as per the intention of the reform. The executive groups of the Chairs and Vice Chairs network and Chief Officers network are also now meeting to discuss progressing their shared responsibilities.

v. Chief Officers have for the past year been working with the King's Fund to review their approach, achievements and direction of travel in terms of embedding and developing their roles and delivering their responsibilities in the health and social care system. The King's Fund report will be published shortly.

vi. At its March meeting, the MSG considered a paper on third and independent sector engagement and involvement in integration in local systems. It was recognised that further consideration of its analysis is required particularly by Chairs and Vice Chairs, and Chief Officers, of Integration Joint Boards. Chief Officers have also committed to addressing concerns raised recently by the Coalition of Carers with respect to ensuring carers are properly supported to fulfil their role on Integration Joint Boards.

vii. Quarterly progress updates on performance are now presented to the MSG using the data set developed to support integration. The Cabinet Secretary will recall that, as reported at the March meeting of the MSG, headline indicators are positive: Integration Authorities are projecting reductions in unscheduled occupied bed day use of 7% by the end of this year and delayed discharges continue on a downward trend. Work is also ongoing to improve the suite of available data, particularly on social care, to understand progress and pressures in the round. Progress data to date has now been shared with the Health and Sport Committee and SPICe (the Scottish Parliament Information Centre), and officials will routinely share future MSG performance data with the Parliament from now on.

viii. Officials from Integration Division continue to meet senior officials from each partnership – the Chief Executives of the Health Board and Local Authority and the Chief Officer of the Integration Joint Board – to discuss progress. These meetings take place in each of the 31 Integration Authorities approximately every 12-18 months. Alongside this ongoing engagement on integration, Ministers and SG officials

undertake annual accountability reviews of NHS Boards. Consideration has begun on how best, and most appropriately, integration may be properly reflected as a partnership commitment in relation to NHS accountability reviews.

4. In addition, Audit Scotland are currently undertaking a review of integration, which is scheduled for publication in November. This is the second of three audits planned by Audit Scotland on integration:

a) The first was published in December 2015. It looked at the emerging arrangements for establishing, managing and scrutinising Integration Authorities. The audit highlighted significant risks that Audit Scotland identified as needing to be addressed if Integration Authorities were to change the way health and social care services are delivered. These included complex governance arrangements, difficulties in budget-setting and delays in planning how to improve services. The work described above is part of our response to these issues.

b) The 2018 audit, on which work is now underway, will follow up on Audit Scotland's previous recommendations and will focus on how Integration Authorities are implementing the Act to reform services around the needs of local communities. This will include highlighting any early evidence of impact on the public and on the way services are delivered. This audit will also complement other audits that Audit Scotland are currently undertaking, including the audit of primary care workforce planning and their annual NHS and local government overviews.

c) The third audit in the series, currently planned for 2020/21, will focus on the impact of the Act, assessing the extent to which integration has led to a significant shift from acute and reactive services towards more community-based, preventative, and sustainable services. This audit will focus on the impact of these changes on improving people's lives.

5. Audit Scotland are undertaking fieldwork to support their review, including case study visits to Shetland, Aberdeen City, Dundee City and South Lanarkshire to see integration in action. They also intend to visit Highland in order to compare and contrast progress under lead agency arrangements there. This year's audit will particularly consider the following questions:

a) What impact is integration having and what are the barriers and enablers to this change?
b) How effectively are Integration Authorities planning sustainable, preventative and community based services to improve outcomes for local people?
c) How effectively are Integration Authorities, NHS boards and councils implementing the reform of health and social care integration?
d) How effectively is the Scottish Government supporting the integration of health and social care and evaluating its impact?

6. Further to the commitments and activity set out above, the Cabinet Secretary agreed at the Scottish Care Conference on 18 May that, as part of reviewing integration,

consideration would be given to progress made in terms of fulfilling the commitment to the Scottish Living Wage for adult care workers and to implementing the Carers Act. This work will include a range of activities, including work already underway on integrated budgets and monitoring of the implementation of the Carers Act and will relate to ongoing plans for wider reform of adult social care

Next steps

7. All of the work described above is already underway, albeit at various stages of development. In order to oversee progress and provide shared leadership, it is proposed that Paul Gray and Sally Loudon convene a small review leadership group, comprised of themselves plus an NHS Chief Executive, a Local Authority Chief Executive and an Integration Authority Chief Officer. The review leadership group will report on progress to the MSG. The larger group already established will continue to meet and will operate as a reference group for the review leadership group.

8. The review leadership group will consider whether it should engage, for example, further advice from the King's Fund, building on their work to date with Chief Officers and on integration in general. It will also consider how best to work with partners across the wider public sector and in the third and independent sectors to ensure progress is made, along with how best to engage with people using services to understand the impact of integration on their experience of care.

9. The Cabinet Secretary and COSLA Spokesperson for Health and Social Care have agreed to write to the Health and Sport Committee following this meeting to provide an update on our approach to reviewing progress with integration.

Recommendations

10. Members of the Ministerial Strategic Group are invited to note the information in this paper, to consider whether further activity is required to ensure our work to review progress with integration is comprehensive, and to consider the proposed role for a review leadership group described above.

JOHN WOOD
Chief Officer, Health and Social Care
COSLA

ALISON TAYLOR
Head of Integration Division
Scottish Government

20 June 2018

KEY RISKS FOR INTEGRATING HEALTH AND SOCIAL CARE

11. Our approach to integration, underwritten by the 2014 legislation, is based on three core principles:

a) Bringing together responsibility for the services and budgets most used by people with multiple complex needs, which were previously managed separately by NHS Boards and Councils, offers the greatest opportunity for redesign in favour of better outcomes, better quality care and improved sustainability.

b) Focussing accountability in localities enables better co-ordination and responsiveness to local assets and priorities, and the greatest opportunity to shift the balance of care for people whose wellbeing is best supported in their own homes and communities. This is the approach set out by the Christie Commission.

c) Weaving requirements for constructive and mature collaboration between statutory (Health Boards, Councils and Integration Joint Boards) and non-statutory (third and independent sector care providers) partners into governance structures offers the greatest opportunity to achieve maximum benefit from total available skills, assets and resources.

12. It is worth noting the scale of integration; approximately 55% of NHS budgets and 75% of social work budgets, i.e., £8.5bn, is now delegated to Integration Authorities.

13. Broadly speaking, though with considerable variation between different areas, we are experiencing a range of risks in the practical manifestation of the principles set out above, as described below.

14. In general terms, although there is a general dialogue about a desire to collaborate – sometimes described in terms of integration being a barrier to collaboration because of the bureaucracy that has become attendant upon it – evidence of willingness to share risk and responsibility is variable. Collaboration is not a problem at the “sharp end” of integrated service provision. There is good and widespread evidence of progress with establishing integrated delivery teams and of multi-disciplinary professional leadership. There are good examples from around the country of service redesign that is improving outcomes for individuals. At the higher management levels of local systems, and in governance arrangements, however, there is sometimes a prevailing assumption that the Integration Joint Board is, or should be, subsidiary to the Health Board and/or Council, and that if that subsidiarity can be established and maintained then the impact of integration in terms of where power is held locally can be minimised.

15. When the legislation on integration was first drafted it was not uncommon for us to hear observations along the lines that it would never happen and that the historic responsibilities of Health Boards and Councils would never be altered so radically. The feeling seemed to be, it’s always been like this and it won’t change; even that it *cannot* change. Now, we hear a great deal that is positive from local systems about progress, in

terms both of measurable improvements in outcomes via better integrated delivery of care in communities, and better relationships with the third and independent sectors and local communities. We do still hear the observation now and then, though, that integration will pass soon enough, replaced by the next Government policy/strategy, and that things will then return to “normal”. The risk from this mindset is not just that integration will fail for want of the will to make it work – significant in itself given the consistency of Ministerial and Parliamentary commitment since 2011 – but that the quality and sustainability of care necessary for the population’s evolving needs will not be achieved.

16. To summarise very briefly, our key concerns are that:

a) The authority and accountability of Integration Joint Boards as demonstrated in practice is out of step with the requirements of the legislation.

b) The consequence of a) is that Integration Joint Boards are being prevented from acting as intended to improve the quality and sustainability of care.

c) As the population ages the risks described below accrue and accelerate; the longer it takes to address these risks, the worse they will become.

d) Current challenges are in part the result of the natural difficulties that accompany change on such a scale. It is difficult to change long-held patterns of governance and leadership especially when there is a strong sense of loyalty to historic arrangements.

e) There is a residual scepticism or inertia around implementation of integration, with what appears to be an emerging trend that Integration Joint Boards are asked to justify their existence and demonstrate attributable success to a higher standard, and more quickly, than Health Boards and Councils.

17. A number of issues are emerging that appear to evidence the broad points set out above. Not all issues apply in all areas, nor to the same degree. Setting them out in this way is not meant to undermine the excellent relationships, and indeed the genuine improvements in care planning and provision, that undoubtedly are emerging in some areas. By bringing them together we can nonetheless offer a holistic, though doubtless incomplete, view of the types of risk that apply to our overall objectives of improving quality and sustainability. Broadly speaking, there is an issue with the extent to which Integration Joint Boards are stepping up to, and being allowed to step up to, their duties. This manifests itself variously, as described below.

18. **Directions** from Integration Joint Boards to Health Boards and Councils vary significantly in terms of detail and scope. This is important because directions are the mechanism via which Integration Joint Boards tell their partners what is to be delivered using the integrated budget, i.e., the means for the Integration Joint Board to improve the quality and sustainability of care. Directions are also the basis on which the Health Board and Council provide services that are under the control of the Integration Joint Board; they should be *seeking* certainty and specificity from the Integration Joint Board. Where directions are detailed they not only provide clarity on service requirements but are also a

manifestation – an important signal – of the Integration Joint Board fulfilling its role and taking responsibility for its decisions. We quite often hear complaints either that the word "direction" is "unhelpful" because it is taken to mean someone is correcting someone else and therefore the interaction is a negative one, or that directions are pointless because they just mean the Chief Officer is directing him or herself to do something. Both complaints reveal a worrying lack of understanding about the nature of governance. "Direction" is just the legal term for one body telling another what to do. It is not the Chief Officer directing or being directed: it is the Integration Joint Board, a statutory agency, directing its statutory partners, the Health Board and/or Council. So, we have two concerns here: a) that members of Integration Joint Boards (themselves either Health Board non executives or elected members), other Health Board members and elected members and senior officers in *some* local systems do not have a full grasp of the nature of their governance responsibilities; and b) that criticism of the mechanics of directions – which it should be noted are already working very effectively in a few areas – is the means for a more general resistance to change. It would be easy for this discussion to become entirely mechanistic or legalistic and we do not want that to be the result. We see the current challenges with directions as symptomatic of broader concerns about sharing the responsibilities and risks of change rather than simply as an end in themselves. Our current work with Chief Officers to develop new statutory guidance on directions will help to address this problem.

19. We see evidence of **unnecessary bureaucracy** in some areas, the effect of which appears mainly to be to perpetuate pre-integration arrangements. In some instances, for example, instead of putting in place a single clinical and care governance committee for all integrated functions to advise the Integration Joint Board, circular arrangements are in place using the pre-existing NHS and Council committees, meeting separately, with some sort of joint sub-committee then advising the Integration Joint Board, whose decisions then go back to the separate committees for consideration. These kinds of complicated arrangements are not required by the legislation nor by any of the scrutiny bodies. Clinical and care governance is one example of this problem. We have heard on many occasions of decisions being referred backwards and forwards between pre-existing committees in the Health Board and Council for consideration with the inevitable effect that the Integration Joint Board's responsibilities become obscured, progress is hampered, and the overall effect is one of understandable frustration. Again, aside from the impediment to practical progress, we have a real concern about the effect of these behaviours on governance. We hear from some areas that it is not clear who is responsible for what – not surprising given the circuitous routes through which some decisions are apparently being unnecessarily and unhelpfully referred. Again, ongoing work with senior leaders in the various agencies, and on statutory guidance, is intended to address this issue.

20. Although the legislation sets out which **functions and budgets** are the responsibility of which agencies, issues remain, particularly in terms of delegating the required functions of unscheduled hospital care from the NHS to Integration Joint Boards. This carries several risks within itself. It means that our core idea for how to achieve our longstanding, unachieved ambition to improve the quality and sustainability of care for people with complex needs – to shift the balance of care by planning across the whole pathway of care – is not being acted upon. It leaves Integration Joint Boards and Chief

Officers in the increasingly uncomfortable position of being legally accountable for services and budgets over which they have little or no meaningful control. And it carries reputational risk for Ministers and Government; Audit Scotland have recognised that the actions required by the legislation are not being consistently carried out in local systems. Work to address this, and also to simplify the processes of delegating budgets generally, is being led by the Finance Development Group, chaired by the Director for Health Finance. The Health and Sport Committee of the Scottish Parliament has recently asked for further information on progress with this aspect of integration.

21. Some Chief Officers and Chief Finance Officers are well supported by an integrated **senior management team** supporting the development of the strategic commissioning plan and the delivery of better integrated services. Others have little direct support, but no lesser responsibilities and accountabilities. Health Boards and Councils are under a legal obligation to provide such support as necessary for the Chief Officer to carry out their functions. Where this issue is causing concern we are offering specific support and appropriate challenge.

DRAFT COLLABORATIVE STATEMENT ON INTEGRATION

The Public Bodies (Joint Working) Act 2014 provides the legislative basis for Health and Social Care integration in Scotland. It puts in place:

- nationally agreed outcomes, which apply across health and social care and for which Integration Authorities, NHS Boards and Local Authorities are all accountable;
- a requirement on NHS Boards and Local Authorities to integrate health and social care budgets for direction by Integration Authorities; and
- requirements to strengthen the role of clinicians and care professionals, along with the third and independent sectors, in the planning and delivery of services.

These outcomes and requirements are not optional and they should be implemented locally to take account of local circumstances. The purpose of integration is to transform people's experience of care and the outcomes they experience. By planning and delivering care collaboratively, we will ensure that health and social care services are firmly integrated around the needs of individuals, their carers and families; that service providers are held to account jointly and effectively for improved delivery; that services are underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve rather than the needs of the organisations through which they are delivered; and that these arrangements are characterised by strong and consistent clinical and professional leadership.

As well as providing adequate funding and using resources in a sustainable way, we must protect our health and care system from the pressures it faces, by delivering fundamental reform and changing the way the whole system delivers care. We will work together to meet higher public expectations of health and social care, which go hand-in-hand with improvements in life expectancy and with the availability of new medicines and technologies that increase demands on the system each year.

We, through our integrated health and social care system, are jointly responsible for tackling these challenges. The Scottish Government, Local Authorities and the NHS share a duty to empower Integration Authorities, to hold themselves and one another to account for making integration work, and to work collaboratively and in partnership with wider partners including the third and independent sectors to deliver improvements. Integration requires a degree of adaptability and compromise by Local Authorities and the NHS to enable Integration Authorities to achieve the improvements needed to ensure the quality and sustainability of care over the long term.

SCOTTISH GOVERNMENT
COSLA
NHS SCOTLAND

JUNE 2018

DRAFT FORWARD WORKPLAN SUPPORTING IMPLEMENTATION OF INTEGRATION

This note sets out proposed actions to flow from the joint SG/COSLA/NHS collaborative discussions on implementing integration.

Activity	Description	Implementation status
Collaborative statement on integration	The January meeting of the large group agreed that a collaborative statement from the SG/COSLA/NHS, reaffirming the spirit of the legislation would be a useful exercise.	Short term Draft prepared for agreement at June meeting.
Collaborative leadership programme	It was also agreed that the SG/COSLA/NHS should look at ways to improve and synchronise leadership development across health and social care. This would have the practical benefit of fostering a shared culture and mutual understanding between leaders in health and social care.	Medium term Officers exploring opportunities for leaders within NHS, local government and the wider public sector to share training and development.
Joint engagement with elected members and NHS non-executive directors	COSLA Health and Social Care Board and COSLA Leaders to be sighted on the work, along with NHS Chairs and non-executive directors.	Short term Papers to MSG, COSLA governance meetings and to NHS Chairs in coming months.
Improvement Service/COSLA elected member training	Work agreed with the Improvement Service to arrange elected member training sessions following publication of two guidance notes for elected members on IJBs.	Medium term
Development of processes/mechanisms for mutual/peer support	Embed expectations of partnership working and shared learning with mechanisms for partnerships to support one another, especially as challenges arise.	Medium term