# Table of Contributors

**Foreword**

Professor Ian Welsh OBE, Health and Social Care Alliance Scotland

---

**Third and Independent Sectors**

Juliet Harris, Together (Scottish Alliance for Children’s Rights)

Annie Gunner Logan, Coalition of Care and Support Providers in Scotland

Disability Equality Scotland

Emma Ritch, Engender

Fiona Collie, Carers Scotland

Ken Milroy MBE, Aberdeen Foyer

Natalie Masterson, Stirlingshire Voluntary Enterprise

Norman Kerr OBE, Energy Action Scotland

Peter Kelly, The Poverty Alliance

Richard Meade, Marie Curie

Ruth Dorman, Deafblind Scotland

Sarah Boyack, Scottish Federation of Housing Associations

Theresa Shearer, ENABLE Scotland

---

**Lived Experience**

Alex Thorburn, Advocate and Community Activist

Donna, Campaigner and Volunteer

Lynn Williams, Unpaid Carer

Margaret Moncrieff, South Lanarkshire Health and Social Care Forum

People First (Scotland)

Sue Beer, formerly Shetland Islands Integration Joint Board

---

**Public Sector and Academia**

Alison Keir, Royal College of Occupational Therapists

Alison Taylor, Scottish Government

Cath Denholm, NHS Health Scotland

Dr Erik Sutherland, East Ayrshire Health and Social Care Partnership

Dr Graham Kramer, Royal College of General Practitioners Scotland

Helen Rainey and Elaine Gifford, University of the West of Scotland

Judith Proctor, formerly Aberdeen City Health and Social Care Partnership

Councillor Peter Johnston, COSLA

Susan Kelso, Scottish Government

Trisha Hall, Scottish Association of Social Workers

Rami Okasha, Care Inspectorate
The integration of health and social care in Scotland is widely recognised as the biggest change to how support and services could be delivered since the creation of the NHS 70 years ago and 50 years since the introduction of the Social Work (Scotland) Act 1968. Integration offers a unique opportunity to achieve innovative and transformational change across health and social care, with planning and delivery based upon an admirable set of principles aimed at achieving health and wellbeing outcomes.

Local partnerships have been set up around the country to enable health boards and local authorities to work together, tackle major challenges and improve health, wellbeing and services. People who access services, unpaid carers, the third and independent sectors are all seen as valuable partners in this worthy endeavour.

By April 2018, Integration Authorities will have been operating for around two years. The ALLIANCE wanted to mark the occasion by asking members and partners to contribute to our ‘We Need To Talk About Integration’ anthology. We think it’s an opportune moment to come together to take stock, assess if we are on the right road to achieving integration’s goals, and collaboratively identify ways to meet and overcome the challenges we face now and in the future.

For many years, we worked intensively alongside our 2,300 plus members and partners on the legislation that underpins integration, which came into force in 2016; advocating for a rights-based and person centred approach. Since then, the necessary shift in working practices and culture towards transformation has started to take effect and many examples of good practice are emerging. However, the picture around the country is uneven and wide-ranging obstacles have been identified across fiscal, planning and operational divides.

In this context, concerns have been expressed that integration may not deliver according to its principles, which threatens achieving the intended outcomes for people. The contributions to this anthology represent a wide spectrum of views and encompass perspectives from people who access services and unpaid carers, as well as representatives from academia, the public, third and independent sectors.

As you will read, experiences have been mixed so far. While everyone strongly agrees that the voices of lived experience, communities and the third sector should be central to planning and developments, the feeling is that this is not working as well as it should be. There are also concerns expressed, for example, about the lack of parity between social care and health, and questions surround the availability of resources to match current and a growing future demand.

However, there is also optimism about the progress made to date, and integration’s potential for the future. There are untapped opportunities waiting to be explored, for example working more closely with the social housing sector and greater cross-sectoral approaches with other public policy agendas like social security and fuel poverty.

We are very grateful to our members and partners for sharing their views with us. The broad range of opinions reflect the very different experiences that individuals and organisations have had of integration across Scotland so far.

One thing is clear, and everyone is agreed: we all want to see integration achieve its vision and to be part of the journey that sees principles put into practice and outcomes achieved.

@IanMWelsh / @ALLIANCEScot
We need to take a children’s rights approach to integration

**Juliet Harris**, Director, Together (Scottish Alliance for Children’s Rights)

Together (Scottish Alliance for Children’s Rights) has consistently emphasised the need for a children’s rights approach to be taken to the integration of health and social care. The UN Convention on the Rights of the Child (UNCRC) sets out the basic human rights that children everywhere have. This includes the right to survival; to develop to the fullest; to protection from harmful abuse and exploitation; and to participate fully in family, cultural and social life. The UNCRC sets out standards in health care, education and social services which are inherent to the human dignity and development of every child. Through the UK’s ratification of the UNCRC the Scottish Government is obliged to take a children’s rights approach to develop and deliver legislation, policy and practice. As such, the principles and provisions of the UNCRC should be at the heart of the planning, delivery and evaluation of all health and social care services. This is reiterated through the Children and Young People (Scotland) Act 2014 which – as well as introducing new requirements for joint planning of children’s services – also places a duty on Integration Joint Boards (IJBs) to report every three years on the steps taken to further children’s rights.

Within integration it has been left to Partnerships to decide whether to include children’s services alongside the minimum requirement to integrate adult services. 20 Partnerships have chosen to delegate children’s health services, of which 11 have delegated some of their children’s social care services. There is wide variation as to what services have been delegated – even if children’s health services have been delegated, some Partnerships have only delegated school nursing, whereas other have delegated all functions. Regardless of whether a Partnership has opted to include children’s services, integration of care has a significant impact on children in many ways.

It’s obvious that changes made to the planning or delivery of children’s health and social care services are likely to impact on children’s rights. However, it’s important to remember that changes to adult services can also have a significant impact on children and young people, particularly those who have a parent, guardian or other family member who accesses health and/or social care services. Research published in 2015 highlighted four specific groups of children who were most likely to be affected by the integration of adult health and social care: young people transitioning to adult services, young carers, young people leaving care, and children whose parents use adult services. Together’s 2017 State of Children’s Rights report reflected on several initiatives being taken forward by IJBs that support the rights of these children and young people.

One case study explores how integration can impact on care experienced young people as they leave care. Throughcare services provided by local authorities usually include personal, social and emotional support, health services, social security advice, accommodation and tenancy support, practical skills training and education and employment support. The Glasgow City Health and Social Care Partnership (GCHSCP) has been working with Who Cares? Scotland to develop an e-learning module for use by up to 9,000 professionals across Glasgow, from various...
services including children and families, criminal justice, homelessness and adults and older people. The Partnership set up a Corporate Parenting Steering Group, made up of representatives from across social and health services, who all worked collaboratively with a Corporate Parenting Officer from Who Cares? Scotland. In line with Article 12 of the UNCRC, every element of the module was discussed, reviewed and edited collaboratively with children and young people who informed and influenced the work. The resulting training module is mandatory for all professionals in the partnership.

“Each partner was able to offer insights into the range of work that happens with care experienced young people across the city, and the combination of that shared knowledge has led the group to produce a very informative, engaging and valuable module that will benefit all of our staff. This piece of work has been a highlight of recent times because it started from a shared desire to create something that would do justice to the principles of Corporate Parenting for our young people.”

Principal Officer for Learning and Development at Glasgow City Council

Another example being taken forward by GCHSCP is an initiative with Families Outside to raise awareness of the impact of imprisonment on families. The project explores how the Glasgow and North Strathclyde Community Justice Authority and practitioners can support families and includes multi-agency training sessions. The training materials were developed with children and young people affected by family imprisonment and explore the challenges they face. Children and young people spoke about their experiences of stigma and how this can be a barrier to them accessing support. Health and social care professionals that have taken part in the training have said that it really increases their knowledge and understanding of the issues faced by children and young people affected by imprisonment and enables them to change
It’s been two years since Scotland’s new Integration Authorities became fully operational; but it’s been twenty years since CCPS first became involved in the project of health and social care integration. Reviewing the organisational archives for the purposes of writing this piece has been a sobering experience in terms both of assessing progress against the grand plan, and of coolly appraising the level of influence our sector has brought to bear.

What were the hopes and aspirations of care and support providers in relation to integration? What were their concerns? And how has any of this panned out in 2018? Let’s have a look.

In 1998, the (then) Scottish Office published ‘Modernising Community Care: An Action Plan’ which introduced two new concepts for us all to consider.

The first of these was the ‘community care £’ (as opposed to the NHS £, or the social work £) which related to the need for public agencies to stop being territorial about budgets. If we fast-forward to the legislative proposals set out for integration in 2011/12 we find this concept preserved, albeit expressed slightly differently: NHS and local government money would, once put into the integration pot, ‘lose its identity’.

Providers were (and still are) in favour of this, not least because it’s the only way we can see how – and here comes another expression from the annals – to shift the balance of care. From our perspective, this wasn’t only about moving funding from institutions to communities, it was also about shifting the focus from acute and crisis care to more upstream support, preventing escalation of need wherever possible.

So how are we doing on that? An awful lot of third sector providers will tell you that the volume of low-level, preventive support they’re commissioned to provide has been steadily reducing. As for money ‘losing its identity’, someone clearly forgot to tell the auditors, since formal accountability for spend is still tracked according to (more or less) the same budget lines as before.

The second concept from 1998 was the ‘tartan of services’ (I know) which was generally understood to mean that the individual threads of health, social care and other services would be woven into a coherent ‘whole systems’ pattern of provision.

Again, this got no argument from providers. We always wanted integration to be about more than just banging heads together in health and social work. We were delighted when the Cabinet Secretary told Parliament in 2012 that in introducing formal requirements for third sector involvement “it was the intention that the voluntary sector is [on the IJB] not just to speak for its own resource, but to influence the spend of the totality of the resource in a much stronger way than perhaps it does just now”.

Sadly, this desire to give us more influence stopped short of providing our sector with actual voting rights on the new bodies. Not us, nor indeed anyone other than the two principal statutory partners, with numerical
We Need To Talk About Integration

parity. The effect of which (you could say) was simply to replicate at IJB level the same impasse from which the whole integration project was supposed to extract us. And having fought so hard to get a place and a voice, we now find that new, supra-IJB regional planning structures have been created of which we have little knowledge and to which we have no access.

What else has been on providers’ collective mind with respect to integration?

First and foremost, I think, that integration should be a means to an end, and not end in itself. I’m not sure we’re there yet. Following publication of the aforementioned ancient text from 1998, a “Joint Futures Group” was established. Here’s an extract from a CCPS briefing paper published at the time:

“A great deal of the Joint Future Group’s attention focused on structural arrangements between local authorities and health boards – including single management of directly-provided services, the mechanics of pooling budgets, and the challenges of harmonising staff pay and conditions.”

As they say in France, plus ça change. The 2014 legislation was, ultimately, all about process, with only a brief nod to outcomes. We said at the time that this may have been because everyone was being very grown-up about the fact that you can’t legislate for culture change, but you can at least set the tone. Fair enough: but four years later, we’ve still not managed to get fully to grips with the metrics for success in any other way. Sure, we have proxy measures – delayed discharge figures, figures for bed days reduced, figures for emergency admissions – but these remain partial and (critically) they exclude social care almost entirely. Again, from one of our briefings:

“Without clear parameters for the shift from acute care to community based preventions, there is nothing to hold public authorities accountable for. There is no clear picture of what success will look like, and no sanctions for failure.”

Other worries included concerns that the integration project was constructed almost entirely to address the challenges in older people’s services. What relevance did it have to learning disability? Autism? Sensory impairment? Children’s services? Despite a recent (and very welcome) push to get mental health further up the agenda, these concerns are still outstanding.

Meanwhile, at the sharp end, voluntary sector staff continue to work with their cross-sector colleagues, and with the people they support, to change lives. I wonder if we had framed the legislation to support them more explicitly, instead of fretting about what all the people in suits were or should be doing further up the chain of command, we might be further along the road?

What needs to happen next? Here’s some thoughts. The integration project needs to stop bulldozing Self-directed Support, and instead be guided by it. Commissioning and procurement need to change out of all recognition, if providers are to be enabled to deliver transformation and innovation. And we need to face up to the fact that marrying a multi-provider price-competitive market (social care) with a top-down directly-funded public delivery system (the NHS) has thrown up all kinds of barriers to the potential of our sector to deliver truly integrated services.

We want this to work: we’ve always wanted it to work. And we’ll play our part in making it work, if we’re given our head.
This article addresses health, social care and integrated services in Scotland relating to accessibility and the rights of disabled people to be able to inform each step of their care pathway. As a Disabled Persons Organisation (DPO), Disability Equality Scotland believes that decisions that affect disabled people should be informed by them. Regardless of what aspect or pathway disabled people find themselves within the integrated health and social care system, their lived experience should inform the conversations that are taking place in Scotland and those opinions are reflected below. The NHS in Scotland has a responsibility for issues that affect disabled people and equally disabled people should have freedom, dignity, choice and control over their lives. The Scottish Government is currently working to implement its delivery plan of the UN Convention on the Rights of Persons with Disabilities. It works with and funds many organisations to help deliver this plan, ensuring the issues which affect disabled people are at the forefront of developments.

**Physical Accessibility**

**The right to physical access**

All disabled people have the right to access health and social care services, free from physical barriers. Disability Equality Scotland’s National Access Survey Team (NAST) is soon to start the process of auditing several NHS 24 sites across Scotland. The aim is to make the premises as accessible as possible for the public and employees.

**Responsibilities**

People accessing services will have the responsibility to inform services and staff of their accessibility requirements before appointments.

**Timely Access**

**The right of equity of access to health and social care**

All disabled people have the right to access health and social care services that they have agreed with their service providers within the stated time.

People also have the right to be informed of the steps that a service provider will take to fulfill the guarantee. For example, accessing treatment in neighboring health or social care areas, private sector facilities, overseas.

**Responsibilities**

People will have a responsibility to attend agreed appointments.

**Respect**

Disabled people have the right to be treated with dignity and respect and service providers should embody human rights principles such as equality, fairness and autonomy. People should have their values and individual circumstances – including disability – taken into account.

**Responsibilities**

People have a responsibility to treat service provider staff with dignity and respect. Any form of abuse or violence will not be accepted.

**Safe and Effective Care**

Service providers should strive continuously to improve quality and safety. Health and social care services should be provided with care, skill
We Need To Talk About Integration

and confidence in a safe environment. Disabled people will also have access to independent advice and support to raise concerns about safety, effectiveness, cleanliness or other issues that they feel may affect their right to safe and effective care.

**Responsibilities**

People will accept a role in and responsibility for their own care. They will be responsible for following advice on medication, treatment and lifestyle and complying with advice on medication and treatment.

**Communication**

Disabled people will have a right to access clear, accessible and appropriate communication. Communicating with people should be done in a clear, accessible and appropriate way. This is particularly important where plans change, or something goes wrong. They should be kept informed at all stages of their journey. Disabled people should be communicated with in a language or format they can understand. This extends to a duty to communicate clearly with family members.

The right includes a right to be told the names of the staff responsible for care and to be told when care is being handed over to another team or provider. People should also have access to translation and interpreting services, access to independent advice and support, a right to ask questions and obtain information about diagnosis, treatment and care from members of the service provider team.

**Participation**

Disabled people should have the right to understand the options open to them and participate fully in decisions about their care and treatment.

Their views should be given the same level of consideration as clinical or other service provider opinion when coming to decisions about their care and treatment.

Service providers are required to show how the views of the people they serve, including the excluded and disadvantaged (including those individuals with disabilities) have been taken into account in their decisions about the development of the services they provide.

**Responsibilities**

People are responsible for ensuring that they have the information to understand what they need to know about their care and to provide consent to treatment. They have a responsibility to take part actively and constructively in decisions and discussions about their health.

**Privacy and Confidentiality**

Disabled people have a right to have accurate, up-dated information stored about their condition and treatment. This information must be held securely. Disabled people also have the right to know how the health and social care services use and share this information and to be given a copy of it on request.

Disabled people also have the right to expect facilities ensure privacy, especially in relation to personal care and examinations. These must be conducted in the appropriate environment. Only those who need to be there, to whom the patient has granted consent or made a specific request for should be in attendance.

**Responsibilities**

People have a responsibility for ensuring information is accurate and relevant. This will help in the diagnosis and treatment of their condition.

**Independent Support and Redress**

Disabled people have the right to clear and simple means of redress. Feedback on the service provided will be actively encouraged.

**Responsibilities**

People have a responsibility to raise any issues which concern them with the staff caring for them as they arise and to do so in a positive and constructive way.
Integration needs to take better account of women’s lives and rights

Emma Ritch, Executive Director, Engender

Care continues to be a profoundly gendered issue, resounding along women’s lives in Scotland. Women take on the major share of responsibility for caring as either unpaid or paid carers, caring formally or informally.

Caring has a significant economic cost to those who provide it, reducing the capacity of informal carers to participate in paid employment. The role of caring for children and adult dependents often limits the extent to which carers can financially provide for themselves and their families. As women make up the majority of formal carers, childcare workers and workers in other care services, the low pay and status of care work is a matter of concern to Engender and to gender equality advocates. The economic impact of caring has an immediate impact on current household income, but also has a future impact on women’s earning and pension income potential.

The social care system is failing many older people and disabled people, as well as their families and carers. Many disabled people are living without essential support beyond basic washing and dressing, or ‘life and limb’ care. Scotland is lacking in a social care system which provides people with the opportunity to take control over their own lives. Though the existing social care system is currently straining under pressure, demographics suggest that demand for care will only increase. Public sector funding is diminishing, and projections show that the number of people aged 75 and over in Scotland will increase by 85% over the next 25 years, a rate faster than the rest of the UK. It is expected that by 2026, the number of adults in need of care will have increased by 30%.

Adequately funded social care supports people in Scotland to participate fully in society – to attend work, to pursue an education, to engage with family and friends, to take part in community activities, and to stay in their own home. Furthermore, an appropriately funded social care system can prevent isolation, exclusion, illness, and poverty. Experts in Scotland have noted that ‘the whole system of funding social care is broken, [and] addressing one issue at a time will not fix it’. Scotland is in need of a system that sees social care support as an infrastructure investment in the social and economic wellbeing of society as a whole.

For those of us who advocate for policies and practices to be reflective of women’s experiences and perspectives, it is hardly surprising to find another example of social policy developed without gender at its heart. We are concerned about the extent to which health and social care integration is not taking cognizance of the impact of its implementation on women’s equality and rights, and particularly the rights of carers.

To succeed for women, integration boards need to have gender-competent governance that is not undermined by conflicts of interest. Strategic plans need to explicitly include equality outcomes for women, including care workers, health workers, and carers, and enable action that will
realise them. Locality and workforce planning must engage with the question of gender equality, including occupational segregation and women’s propensity to engage in unpaid care. Failing to count can mean failing to plan for or manage, and we are concerned both at the lack of gender-disaggregation in the core suite of indicators, and in the content of the indicator around unpaid care. We have greater ambitions for carers than that they “feel supported to continue in their caring role”.

Engender has spent two years talking to organisations and individual women about what women want in Scotland. This was collaborative thinking for the purpose of envisioning how we might get from where we are to where we want to be.

We want a social care system that reflects social justice, human rights, and gender equality ambitions. We need a modern, nationwide infrastructure of social care support that is underpinned by a sustainable funding model. Carers should have minimum entitlements to breaks from caring, should ‘consent to care’, and be able to access an independent social care tribunal to protect the rights of carers and those to whom they provide care.

We want a good life for carers and cared for people in Scotland, and we know that policymakers’ failure to consider gender plays a significant part in preventing that from happening. The implementation of health and social care integration needs to take better account of women’s lives and experiences if it is to succeed in improving outcomes for Scotland’s people.
Integration and carers

Fiona Collie, Policy and Public Affairs Manager, Carers Scotland

When work began over ten years ago to encourage more formalised joint working between health and social care, there was much hope that this would benefit carers. However, progress was patchy and when legislation to formally integrate health and social care was mooted, the national carer organisations were fully behind this.

Audit Scotland has already reported on some of the main challenges to be overcome if the integration of health and social care is to, in reality, transform the ways that health and social care services are delivered and we know that a further audit is planned for 2018, which we await with interest. The first audit was clear of the need to shift resources, including the workforce, towards more preventative and community-based models of care that are affordable and sustainable. They noted that “some progress is being made in developing new models of care but... this has yet to translate to widespread change.”

Although we are still in the early days of this significant and transformational change, it is clear that progress remains inconsistent across partnerships and that carers often find themselves, and the person they care for, caught between two different systems; often unintentionally working in conflict with one another. We know that integrated support can help solve some of these issues but evidence from carers continues to say that the intention has not yet become a reality. We also know that partnerships are at different stages of progress and, that there are many examples of positive holistic initiatives locally, most recently in pre-implementation pilots for the Carers (Scotland) Act 2016, but there remains much work to be done.

Whilst we want to be clear – as we have been all along – that dealing with delayed discharge is not, nor should it be, the only driving force for integration, it is one element of a system where integration can provide a more holistic response.

However, to illustrate some of the issues with progress (an issue consistently raised by carers) an example of when problems occur (and where better integration can help) is that of hospital discharge.

Carers Scotland’s annual State of Caring research has consistently found that carers were not routinely involved in hospital discharge. Most recently in 2017, a quarter of carers were not informed about a planned discharge and similar proportions were only involved at the last minute. Half of those surveyed said social care services were not in place and 15% that not only was discharge too early but it resulted in the person being readmitted to hospital, with resulting higher costs incurred.

We continue to see the consistent pressure on one part of the system (the NHS) to discharge without a clear understanding of the costs in another part (social care) and most importantly to the health and wellbeing of carers.

We hope that the new Carers Act, with duties to ensure that carers are informed and involved in discharge, will begin to make inroads on this and similar issues. We know that in most cases integrated partnerships will lead on planning and progressing implementation. This gives the opportunity to identify the ways in which integrated services, including services from the third sector and wider employability and further education services can help build the environment that supports both carers and the person they care for.
We Need To Talk About Integration

Whilst we know that health and social care face significant financial challenges in responding to increased demand, expected increases in older people will create a greater demand for unpaid care. It is vital that in seeking to address these challenges, integrated partnerships do not lose sight of delivering the national health and wellbeing outcomes for carers: to reduce the negative impacts of caring and maintain and improve their own health and wellbeing.

Returning to State of Caring, 64% of carers said their physical health had worsened and 74% said they have suffered mental ill health as a result of their caring role. We also know that a significant proportion (41%) said they have put off their own health treatment as a result of caring. This ranges from going to their own GP and hospital appointments right through to putting off planned surgery.

Partnership strategies should outline how they intend to support carers through the Carers Act but also should be able to identify opportunities to deliver health enhancing support for carers, recognising that delivering replacement care to enable carers to take part in activities that improve their health, to attend to their own health needs and to have regular breaks will help deliver on health and wellbeing outcomes. However, it is important that partnerships are able to measure the impact of these activities, beyond identifying where carers have had an adult carers support plan or “feel supported”.

In delivering improved integrated support for carers, we continue to believe that the involvement of carers’ representatives on Integration Joint Boards (IJBs) can make a big difference in understanding and developing the right models of support. In some areas engagement is more meaningful and they are well supported, but they are not yet equal partners across Scotland.

The Carers Collaborative facilitated by the Coalition of Carers in Scotland have worked with carer representatives on IJBs to develop a best practice remit and expenses policy. Some of the main issues they have included are: offering payment for involvement, particularly where carers are out of pocket by having to take time off work, but as a minimum ensure that all carer reps are paid expenses and offering replacement care; providing opportunities for carer reps to have items added to the agenda; ensuring that papers are disseminated early so that carers have time to consult with local carers; involving carer reps in all decisions including decisions about tendering and commissioning; and offering induction and ongoing training involving all members of the board.

In conclusion, the national carer organisations believe that integration continues to have huge potential, in using resources better by designing services with the people who use them to deliver holistic, seamless support for carers and those they care for within their own communities. But there remains much work to be done. We look forward with interest to developments and to supporting carers to be at the heart of this work.
How our IMPACT Programme supports integration

Ken Milroy MBE, Chief Executive, Aberdeen Foyer

Jo, IMPACT Member

Jo’s story is not unusual. Many if not most of those who have participated in Aberdeen Foyer’s IMPACT self-management initiative have significantly improved the quality of their lives.

In 2017 some 159 referrals were made to IMPACT. Of these, 99 engaged in the programme and, to date, 22 have successfully moved on as volunteers, into education and a few have gone into work. Change needed to be stimulated and supported but has brought extraordinary results for those involved.

The Foyer’s work has been recognised by others. In 2016, IMPACT was awarded Self-Management Project of the Year by the ALLIANCE. In 2017, IMPACT won the Aberdeen City Health and Social Care Partnership HEART Award for Enablement (Empowering People) Award. That same year we also won The Herald Society Health and Social Care Integration Award.

IMPACT has changed the way Aberdeen Foyer works with others involved in health and social care – we are a respected delivery partner; we are given opportunities to speak at events; showcase our work and to share our successes.

Like other areas of our work, greater emphasis is placed on early intervention and prevention. IMPACT is a non-medical intervention for those who have experienced long term health issues such as anxiety, depression, personality disorder, trauma and self-harm. The programme has demonstrated just how self management can bring about changes. It is about the quality of life – a sense of purpose, a sense of worth, a sense of community and ultimately a sense of ownership – it’s not something you can get from a GP’s prescription. You have to work at it.

IMPACT also aligns with Scotland’s House of Care: it is a great example of how community-based resources and assets are part of the wider ‘health and care environment’ that people live within. The foundation of the house

@aberdeenfoyer
is “more than medicine”, representing these wider community resources. Aberdeen Foyer is such an asset for the people of Aberdeen, and also supports the left wall of the house – namely informed and empowered individuals who are better able to manage their own health.

Health and social care integration is the biggest, and arguably, most complex public service reform we have seen to date. Perhaps the biggest change we need to see through reform is a shift from crisis intervention to longer term prevention strategies that cut across public policy – health, social care, education, employability, and community development.

IMPACT is a powerful example of what can be achieved through limited resources, promoting a self management approach. Integration Joint Boards across Scotland need now to draw on the successful examples of this approach and embed it in their future plans.

Organisations like the ALLIANCE can also play a key role by showcasing the work they have invested in and in helping to broker relationships between Integrated Joint Boards and effective initiatives like IMPACT.
Clackmannanshire and Stirling Health and Social Care Partnership is unique: it is the only partnership that comprises one Health Board – NHS Forth Valley – and two Local Authorities – Stirling Council and Clackmannanshire Council. This makes it at some levels challenging and at other levels one of real opportunity – because if it can work here in central Scotland, where two local authorities experience very different demographics and health profiles (and even with the main acute hospital in another local authority area) then it can certainly herald in a new era of successful health and social care delivery throughout Scotland.

As one of the largest Integration Joint Boards, the very logistics of having so many people in one room can be tricky, but it can also be a huge opportunity.

Coming together bi-monthly for the first two years, and now quarterly, has stimulated debate, allowed us to get to know each other better and helped us reflect on difficult issues and overcome cultural barriers, that we would not have known about, had everyone not been at the table.

As one of the Third Sector Representatives for Stirling, I have had the opportunity to listen to and learn about the experiences of our workforce, our technological advances, and our pharmaceutical challenges first hand. Listening and learning has helped me as a Board member and a leader of the third sector in Stirling, to better scrutinise proposals, champion alternatives, co-produced models of delivery and ensure that our collective focus on national outcomes, prevention and early intervention remain at the heart of all decision making.

So, have we as a Partnership succeeded in transforming all care to be outcome focused, proactive, not reactive? No, of course not, it’s only been two years. Health and social care integration is the biggest change in public service since the very creation of the National Health Service in 1945.
Our task is mammoth and complex. Changing workforce cultures and practices that have developed over decades towards patients / clients / carers / families / community. Trying to find collective solutions and carve out investment for prevention and community development from already over-committed budgets. Democratising the design and delivery of health and social care services through co-production. It was never going to happen overnight, or even 730 nights.

We are progressing and learning and thinking in a new way as we do so. Our partnership can certainly celebrate much in terms of that progression already: an easy-read Strategic Plan that cascades the core values of self management and community supports; a new Market Position Statement that recognises the critical importance of community based resources and will start shaping imminent strategic commissioning; and a jointly hosted Health and Social Care Forum which feeds into the decision making structures of the Partnership, giving opportunities for feedback and accountability for the third sector representatives and wider partners.

We are progressing when we open up the Integration Transition Care Fund, through a new small grant scheme managed by the TSIs to award innovation and improved ideas from local third sector organisations across Clackmannanshire and Stirling. This has enabled the highly-regarded Recovery Community based across Forth Valley to build in new opportunities for its widening and recovering participants in Clackmannanshire by holding a bread and baking session prior to its already established Recovery Café. This has proved to create interest, conversation, fun, value, even physical improvement in people who have been in addiction situations over a long period. They will be presenting their produce at a new Farmers’ Market also being set up by the Clacks TSI shortly.

We certainly can be judged to be progressing when we take bold decisions to transform care hand in hand with our communities. The Neighbourhood Care Team is a multi-disciplinary team of district nurses, social workers, re-enablement staff and community workers, that will assess, co-ordinate and deliver health and social care to adults living in the south west rural area of Stirling. Based on the Buurtzorg model, the team will firmly place the client at the centre and will recognise the important role support networks play in enabling people to live safe and well in their community.

The transformation of health and social care is a journey, and we are moving, but where are we going, and what is the role of the third sector interface and the wider third sector? At the moment, most TSIs are involved in integration by sitting as a third sector representative on the IJB or convening a Health and Social Care Forum. As advocates for the third sector, we are gaining inroads in new ways to commission services that extend choice and flexibility. Yet, in my opinion, the role of the TSI is bigger and all together more intangible than this. To truly achieve our aspirations, we must give confidence to the real ‘change-makers’ in our midst: our community befrienders, lunch clubs, neighbourhood groups, and third sector social care providers. We must give them confidence that it’s ok to chop on each other’s doors and start a conversation, confidence that unnecessary barriers will be removed if they want to help others, confidence that outdated and misplaced attitudes on the ‘professionalism’ of our third sector workers will be robustly challenged.

Furthermore, volunteering, or being an active citizen, is a powerful way to get involved and be connected, but we must address the social and economic barriers that exist for people who experience the most deprivation and their barriers to take those steps to become involved. To achieve the real potential of integration, all of us from managers, GPs, nurses, third sector providers and social work practitioners must also work hard to reverse the weakened community bonds and increasing levels of isolation — arguably as keen a factor in ill health and deteriorated quality of life as smoking or drug use.

Investing in communities takes time, and it takes some money, but it is an essential building block in transforming health and social care integration through its next phase of development and transforming it for the better — for the care of our residents, for the value for our public bodies, and for the health of our nation.
Integration can help tackle fuel poverty

Norman Kerr OBE, Director, Energy Action Scotland

Fuel poverty has a very real impact on health and social care in Scotland but there are green shoots of hope to show that, conversely, the integration of health and social care can support progress in tackling fuel poverty.

Like so many organisations, Energy Action Scotland shared the historic frustration of health care, social work and social care professionals unable to have the type of conversations that could lead to the support of households and individuals. We have trained 10,000 workers who work at the front line and we know how hard it is to find ways of joining up services around people to keep them well and at home when that home is hard to heat, cold and damp. It is, however, inspiring to hear how people are beginning to find ways of doing just that, in some Health and Social Care Partnership areas faster and better than others, but change is happening and that will save lives and support crucial services where it works.

GPs need support to recognise the health effects of fuel poverty. From cold and damp at the better understood end of the scale to the inability to cook or refrigerate food at the other. Social care workers need to be alert to the signs of a home that is difficult to heat to better anticipate the health problems that are likely to result.

The stark facts are that fuel poverty kills six people in Scotland every day of winter. For every one degree drop in temperature below five degrees centigrade, GP consultations for respiratory illness in older people increase by 19%. Add to that the fact that 9% of hypertension in Scotland could be prevented by maintaining an indoor temperature above 18 degrees centigrade and we can clearly see why services struggle to cope when 649,000 households in Scotland live in fuel poverty.

Away from primary care, Energy Action Scotland hears from front line workers involved in resolving delayed discharge caused by an unplanned hospital stay resulting in disconnection for individuals on pre-payment meters. We hear too of delayed discharge caused by a patient’s self-disconnection, meaning that they are unable to return home with equipment that requires electricity or medication that requires refrigeration.

In some parts of Scotland, fuel poverty advisers are part of the team working alongside community links practitioners, multi-disciplinary primary care and community discharge teams. These are areas that acknowledge the impact of fuel poverty on households and communities and are actively seeking solutions for households that make the choice between heating and eating every day, households that suffer from respiratory and other conditions caused by damp and mould.

The long term, sustainable solutions will come from housing working more closely with Integrated Authorities. Local strategies like the ‘fabric first’ approach to make homes in a community easier to heat will reduce the burden on health services, keep people out of hospital and enable them to return home faster when they do. These are the areas where we need to speed the pace of change. 649,000 households and the lives of everyone in each of those make that an urgent priority.

@EAS_Scotland
Reforming the way public services are delivered has been on both the political and practice agenda in Scotland for many years. It was the Christie Commission report in 2011 that perhaps best captured the urgent need for reform in the way that we deliver services in Scotland. Their finding that some 40% of public spending was on so-called ‘failure demand’ (spending to fix problems that could have been addressed earlier) focused the minds of everyone involved in the delivery of public services. Shifting resources from fixing problems after they occur to preventing them in the first place should always be our priority whether we are operating in the public or voluntary sectors. Prevention should be and is at the heart of the continuing development of health and social care integration.

Of course, throughout the period since the Christie Commission in 2011 and the passing of the Public Bodies (Joint Working) Act 2014, public services have been operating in the shadow of austerity, meaning that efforts to focus on prevention have been under pressure. Policies like the two child limit and the freeze on most working age benefits have had a significant impact, and levels of child poverty have begun to increase once again. Bringing about the integration of health and social care was always going to be a challenge but in this context, with increasing poverty levels compounding Scotland’s stubborn patterns of health inequalities, that challenge has been amplified.

Yet it has also underlined precisely why integration, and the accompanying focus on prevention, is so required. Increasing poverty will make the task of addressing Scotland’s stubborn pattern of health inequalities all the more difficult, but also all the more necessary. In amongst the various challenges that Integration Authorities face, it is vital that they remain true to the National Health and Wellbeing Outcomes, and are focused on tackling health inequalities. This can be done, in part, by further integrating rights based approaches within health and social care. We have seen some progress in this area in recent years, with Self-directed Support allowing more people to make informed choices about their care. But there is much still to be done, with the pace and scale of change not yet being sufficient given the stated ambitions of the integration agenda.

We also need to do more to truly embed a more holistic, person centred approach to care. Innovations like the Links Worker programme have been hugely welcome and impactful in addressing the social determinants of ill-health, but we still hear too often about ‘hard to reach groups’ when we should be talking, conversely, about ‘hard to reach services’. Making services easier to access for people living on low incomes may pose challenges, but it is fundamental to achieving a fairer Scotland where everyone is able to access the rights, services and support to which they are entitled.

Reforming and streamlining our health and social care service was never just about saving money. Fundamentally, it has been an opportunity to recast our public services in ways that the Christie Commission, and many others, has sought to do. This means much more than developing more coordinated service delivery, important though that may be. It is about...
putting those who use those services at the heart of their design and development; not just participation for participation’s sake, but true co-design and co-production that has poverty and inequality alleviation as one of its key guiding principles.

With a new Scottish social security system being established based on principles of dignity, fairness and respect, we find ourselves at a potentially transformative juncture in Scotland’s journey towards a more just and compassionate society.

The ongoing integration of health and social care must be seen as part of this journey. It has the potential to transform lives and contribute towards a loosening of the grip of poverty and inequality. Two years on from the start of Integration Authorities’ formal operations, the time is right to re-commit our efforts to ensuring that it does.
We Need To Talk About Integration

Only one chance to get it right – integration and palliative care

Richard Meade, Head of Policy and Public Affairs - Scotland, Marie Curie

There can be no doubt that integrating health and social care is the right thing. It makes sense for just about every aspect of care and especially for palliative care, which supports someone who is terminally ill and approaching the end of life.

Palliative care aims to treat or manage pain and other physical symptoms, as well as social, psychological, emotional and spiritual needs. It can support any terminal illness including heart failure, cancer, chronic obstructive pulmonary disease (COPD), dementia, frailty and others. It can be introduced from the point of diagnosis, which means that people may receive care for years, months, weeks, days or even hours.

People who are living with a terminal illness are likely to need a range of services throughout their illness and these may be delivered in a variety of settings. This can include the GP practice and district nursing services, social care, acute services, care homes, and specialist palliative care services such as hospices or community palliative care. Scottish Government statistics show how terminally ill people can move between care settings. Around 87% of a person’s last six months of life is spent at home or in a community setting meaning that they will spend on average 24 of those days in a hospital. Navigating all of these services can be a huge challenge for patients, families and professionals alike.

Someone who is terminally ill should move seamlessly between services as they need them, with their wishes at the centre of their care plan. Getting palliative care right can make a big difference for families; it can afford someone the chance to be cared for at home surrounded by loved ones, it can be the opportunity to visit family or attend a celebration, such as a wedding, it can be as simple as getting an evening gin and tonic at the hospice they are staying at or having someone walk the family dog.

The sad truth is that we estimate that about one in four people who need palliative care in Scotland do not get the care and support they need before they die. This means they miss out on some or all of those services and the chance to continue to live the life they want until their death.

A significant amount of specialist palliative care services are delivered by the third sector in Scotland. There are twelve independent adult hospices, as well as the two hospices provided by Marie Curie, and two children’s hospices. Marie Curie also provides palliative care nursing services in communities across Scotland, last year supporting over 8,300 patients out of the 45,000 who died with a palliative care need. Scottish hospices supported 19,000 people of all ages last year.

Palliative care services must work in harmony with health and social care services if a person and their family is to receive the support they need and make the most of the time they have.
left. The integration of health and social care, by bringing together local government, the NHS and the third sector, should make this more of a reality for more people. The Scottish Government recognised the importance of palliative care services for health and social care and included a commitment to double palliative care services in the community in its Health and Social Care Delivery Plan14.

Palliative care makes economic sense too. There is a growing evidence base to show that those in receipt of palliative care are more likely to be cared for and die at home and much less likely to be admitted to hospital either through an emergency or an unplanned admission15. If integration authorities are looking to make efficiencies and ease the burden on acute settings then ensuring that palliative care services are a priority and well integrated could play an important part.

At the moment there is a very mixed picture across Scotland in terms of the progress we are making with integration. It is by no means all bad, but there remain some significant challenges in many areas, especially for the third sector.

We have heard the term strategic commissioning used a lot in the ambition of integration, but some of the basics of this approach have yet to be realised.

This is particularly the case in developing true partnership working between the statutory sector and the third sector. We need to see the third sector involved early, using its expertise, to understand the needs of local populations, and then developing plans together for meeting those needs through integrated services. This isn’t happening in every integration authority.

We know that finance is a challenge, but the third sector needs sustainable funding in order to invest and innovate in services. Unfortunately, we see that far too many third sector organisations are relying on twelve month funding contracts with limited evaluation, which bring considerable uncertainty. The Scottish Government stated in its 2018 Programme for Government that it will look to ensure three year rolling contracts for the third sector. This needs to be common place in integration authorities too.

There are already lots of examples of good practice across Scotland, but there is also a clear absence of shared learning between integration authorities which will undoubtedly lead to a variation in quality and, potentially, postcode lotteries.

There are lots of challenges, but none of them insurmountable. We only get one chance to get it right for someone who is terminally ill and dying. By working and planning together, drawing on our joint expertise and understanding, and delivering in partnership we have a much better chance of making sure that this is possible for everyone in Scotland.
As someone who has worked in both health and social care, since qualifying as a nurse in 1981 and a social worker in 1994, I have been on a remarkable journey. My need to become dual qualified was in part (big part) due to the lack of integration within the sectors. The interdependence was always there however the ‘boundaries’ were ever present, right down to the differing languages and perceived cultures.

The NHS and Community Care Act 1990 and subsequent Community Care and Health Act 2002 provide a legislative framework for ‘joined up’ working where health and social care are obliged to share responsibilities and resources. The then Scottish Executive accepted recommendations of the Joint Future Group which were reported in “Community Care: A Joint Future” in December 2000. The key elements of which featured in “Our National Health: A Plan for Action, A Plan for Change”. The main aim of this report was to find new ways of improving joint working and to rebalance services for older people away from institutional care towards services in the community. With this as the driver I moved to work in a multi-disciplinary team which was co-located and joint funded, “integration was here”, although it has taken a further sixteen years for us to reach the point of integrated authorities. Reflecting on this journey I can say “yes, we are on the right road”.

When I joined the world of sensory impairment seven years ago there was little, if any, concept of where individuals who lived with Deafblindness (severe dual sensory loss), sight or hearing loss/impairment, were considered in the world of health and social care. These seemed to be ‘conditions’ which formed part of a tick box on an assessment forms, or where you attended audiology, ophthalmology or opticians. There was very little recognition that sensory impairment required to be recognised in a person’s overarching ability to live well, stay well and get well. There was a lack of understanding that the impact of little or poor accessibility to information, whether this be spoken, written or visual information, had on a person’s ability to engage in their health and social well-being, e.g. how can you know you have a hospital appointment if you cannot see the letter to read it or hear the message?

I have observed, however, that in relation to integration, the progress of drawing the voluntary sector closer into planning and decision-making processes is happening, although there remains a perception that we are still viewed principally as ‘suppliers’ rather than partners. I remain aware that what is required of us all by government is ‘public service reform, not simply public sector reform’.

Collaborative working remains very much a public sector development, rather than a public service development. Although there are great examples across the country of collaboration I believe we have not yet found a satisfactory way of enabling Integrated Authorities to harness the expertise of voluntary sector organisations, far less of people who use services, in community-level needs.
assessments, planning or decision-making.

I continue to believe that certain statutory responsibilities could be placed upon the voluntary sector in its own right, with funding, and not just by delegation from public authorities. There is, for example, a clear role for voluntary sector service providers to become much more involved in the assessment process for individuals, including acting as the ‘lead professional’ in relation to assessment for sensory impairment services, there is currently only one example I am aware of across Scotland, in Aberdeen City.

All of this said I am delighted to be in a position to claim that integration is helping ‘join the dots’ in the planning of how services and supports are being made accessible for those living with Deafblindness. The British Sign Language (BSL) (Scotland) Act 2015, and inclusion of tactile BSL within the body of the Act, means that in the development of National and Local Plans all public bodies, including integrated authorities, must set out their plans for ensuring that “Scotland’s ambition to be the best place in the world for BSL users to live, work and visit”. The Scottish Government made it clear that it was not intending to impose change from above: rather, those involved in planning, providing and using public services had a significant part to play in collaborating to shape the way in which change happens. True innovation and transformation in action, through not just how the initial National Plan was developed, but, how we take this forward to develop local plans.

It’s an inspirational time to be part of the journey of change, and I’m looking forward to the next 30 years.
We Need To Talk About Integration

A view of integration from the social housing sector

Sarah Boyack, Head of Public Affairs, Scottish Federation of Housing Associations (SFHA)

Housing associations and co-operatives are independent, not-for-profit social enterprises – mostly charitable companies. They are part of the social housing sector and supply quality, affordable homes to those in need.

They can be large or small; rural or urban; providing for general or very specialised needs. Many of these organisations are based in communities; some cover a wide area. Some focus primarily on providing housing and support to people with particular needs, such as older people.

There are currently 158 housing associations and co-operatives in Scotland providing more than 280,000 homes and over 5,000 places in supported accommodation, plus factoring services for properties in private ownership, mid-market rent and shared equity housing.

The homes provided by housing associations and co-operatives are typically of high quality, with good energy efficiency standards that help to keep fuel bills low for tenants and meet the Scottish Government’s targets for tackling climate change.

But it is important to emphasise that housing associations are not just landlords. They are not just letting agents. They do not just deal with bricks and mortar.

While it is true that housing associations across Scotland provide warm, good quality homes at affordable rents to many people in housing need, they do a lot more. Housing associations improve health, enhance life chances, transform communities and cultivate resilience of their tenants and the communities in which they operate.

If the goal of health and social care integration is to keep people living safe and well in their

own homes, housing associations would be an ideal partner to involve in strategic planning and working groups. Who better to talk to about keeping people safe and well at ‘home’, than people who do that for their day job?

Integrated Joint Authorities are encouraged to think about the role of housing as part of Strategic Commissioning through the production of a Housing Contribution Statement. A housing focused analysis of the 31 Strategic Commissioning Plans revealed that the contribution that housing could make had been recognised by many Integration Joint Boards, as the quotes below illustrate.

“The housing interface with health will be crucial to the success of integration.”

“Housing options needs to be a key feature of our integration of health and social care services.”

“Having a suitable affordable place to stay is at the very core of addressing an individual’s health and social care need.”

“Housing is a key partner and makes a vital contribution.”

“Housing is an essential feature of health and wellbeing with providers giving a critical link to the wider community.”
In some areas, therefore, housing has a key position within the Integrated Joint Boards. The insight that housing providers provide, with the ability to think strategically and operationally about ways to promote good health, and meet the changing needs of people as they get older, has been seen as invaluable.

In other areas, the role of housing, and what housing professionals can offer as part of health and social care integration have not been fully recognised.

Health and social care integration is the biggest change to how our public services are delivered and the housing sector wants to play a full part. Great progress has been made in many parts of the country, but more could be done. The Scottish Federation of Housing Associations, as the membership body for the housing associations and co-operatives across Scotland is ready, willing and able to assist in building the networks necessary to put housing at the heart of health and social care integration. If you would like to find out more about the work of our members, or would like to be put in touch with housing organisations working in your area, do not hesitate to get in touch: you can find out more on our website – www.sfha.co.uk
We need to change the conversation about integration

Theresa Shearer, Chief Executive Officer, ENABLE Scotland

Integration has the potential and power to lift citizens out of traditional models that no longer best support them to meet desired outcomes, either individually or collectively as a nation, and there is no doubt that this is a welcome direction.

As a sector, we have felt a little on the fringes of the integration agenda – monitoring Integration Joint Board (IJB) progress, locality planning, figuring out how the third sector voice can be more representative. We are now two years in, and the direction set by the integration opportunity is still clear – even if sometimes the processes are not. It is a unique opportunity to achieve innovative and transformational change across health and social care, driven by person-centred and rights based approaches. Great! So let’s seize it.

I would argue that those of us in the social care sector don’t have to wait to be told what to do, or to respond to the agenda set by IJBs. I would argue that we have to influence it, and that we have to influence it by offering something different into the agenda – it is designed to be the catalyst for a transformational change after all.

This is OUR challenge. And let’s be clear – a challenge it is. In order for the integration agenda to succeed, it relies on a thriving social care sector, full of quality organisations with strong values, delivering quality support to people who are living great lives. In the current context:

- Total spend on social care in Scotland is £3.1 billion; £1.6 billion of this is spent on commissioned social care services from the third and independent sectors.
- ENABLE Scotland is one of over 1,000 registered providers of adult social care services in Scotland. Over 600 of these are voluntary sector.
- A 2016 Audit Scotland report forecasts that an additional spend of £667 million would be required by 2020 in order to deliver current services, against a challenging forecast of a cut of some 20% in public spending by 2020.

So the challenge is how to retain that quality of provision in an era of decreasing public spend. And I do believe that the answer lies in integration, but not exclusively with health. I believe that the integration of some social care provision must be considered in order to pave the way for the integration of health and social care services.

In the sphere of learning disability, we are aware that ENABLE Scotland is one of circa 300 providers of social care for a population of 12,680 adults who have a learning disability and receive a social care budget. We are one of 600 third sector social care providers in Scotland. There are clear opportunities – and a clear impetus – for the operations which support the delivery of social care across all of these providers to be reduced through collaboration,
potentially releasing millions of pounds of public funds back into the delivery of best quality frontline social care support, including helping us to fund digital transformation to enable more efficient working practice.

Beyond this, in an era where we compete with each other to recruit and retain the best staff to support people living in the same areas, now must be the time to properly consider the merit of locality/collaborative commissioning, particularly of overnight support, as opposed to (often) needs-led provider-focused commissioning.

The skillset of the social care workforce is broadly transferable across different groups.

Alternative commissioning models have the potential to drive sector transformation and encourage collaboration and the resulting efficiencies of public spend to be refocused on frontline service delivery. As a sector, now is the time to work together and offer these solutions to our commissioners and customers.

Even better, a focus on integrating the provision of social care services, led from within the sector, would also pave the way for smoother integration with frontline healthcare services.

This is the kind of talking about integration I would like to see more of across the third sector.
We Need To Talk About Integration

Involving people meaningfully can help speed up integration

Alex Thorburn, Advocate and Community Activist

I am a member of the Health and Social Care Action Group and the Adequate Standard of Living Reference Group of Scotland’s National Action Plan for Human Rights, as well as the Dumfries and Galloway Health and Social Care Integration Strategic Planning Group.

I was involved with integration from the outset, mainly but not exclusively within Dumfries and Galloway.

The structure of the Strategic Planning Group (SPG) and how it was to influence integration within the region was flawed from the beginning.

At the first meeting of the SPG we introduced ourselves – all 45 of us. It was more of a conference than a planning group.

The full group never met again in that format, simply because it was impossible to make decisions with 45 people around the table and allow for input from all the registered participants.

Meetings of the members took place along the lines of the old District Council Boundaries of Annandale and Eskdale, Nithsdale, Stewartry and Wigtownshire and then information was drawn together from each of them to form opinions.

The Third Sector participants quickly identified the main barriers to effective integration as being:

- Structural Empires
- Financial Empires
- Reluctance to change the culture
- Demolishing policies and constructing new ones
- Involvement and engagement with people using both health and social care services
- How to gather the views of, and involve, disadvantaged groups
- Participants using a great deal of their time but little change being effected
- Process being “officer-led”
- Living up to the “hype” about “new ways of working”
- Promises made but never kept, e.g. Thematic Groups
- Lack of meaningful engagement with the real decision-makers
- Different structures in different IJB (Integration Joint Board) areas
- Lack of transparency
- Lack of accountability
- People with lived experience being too far removed from decision-making
- No meaningful feedback to participants – how did their input make a positive difference?

As far as the public were concerned, Health and Social Care Integration in Dumfries and Galloway appeared to be more of an intellectual exercise than anything that would create a positive impact on their lives.

The initial information provided was enthusiastically received by third sector organisations but the public were still quite confused by the proposed changes.
The merging of budgets, two different empires and cultures has proved to be so difficult to attain, mainly due to the numerous barriers mentioned in my earlier bullet points.

The geography of Dumfries and Galloway has not helped with integration of services.

It is approximately 115 miles from Stranraer to Langholm and about 60 miles from Sanquhar to Gretna and within the region there are so many communities with different outlooks and agendas.

For instance, around the north of Nithsdale there are the old coalfield communities and in the far south many people in Gretna relate more to Carlisle and Cumbria than they do Dumfries and Galloway.

It is often said by people living in the far west of the region that it is 75 miles from Stranraer to Dumfries but it is 150 miles from Dumfries to Stranraer. This is a reference to their feeling isolated from decision-making processes undertaken in the capital town of Dumfries.

Historically, Langholm has always regarded itself as a part of the Scottish Borders and often looks to that region for support rather than to Dumfries. It is only approximately 20 miles from Langholm to Hawick but more than double that distance to Dumfries and Galloway’s power-base.

On a more positive note, Health and Social Care Integration within the region of Dumfries and Galloway may eventually prove to be a success but the numerous barriers must first be overcome before the benefits and rewards will become evident.

However, as I anticipated at the beginning of the integration process, the final achievement of the original goals will take much longer than in some areas of Scotland that have a bit more cohesion and a more accommodating geography, where any barriers may be more easily destroyed.

These barriers can only be dismantled quickly with the direct involvement of people who are service recipients. It is they who have lived experience of these barriers and their voice is often either weak or is completely disregarded.

There was an appetite at the beginning of the integration process for people with lived experience to become involved in helping to change the prevailing cultures and working arrangements within both health and social care.

However, as with many projects that find it difficult to attain the original goals set for it, the lack of positive and constructive feedback on how their contribution has made a positive change has resulted in a general apathy amongst many who were so keen at the start of the process.

Dumfries and Galloway Royal Infirmary (DGRI) has now moved to a new site at the Garroch, just west of Dumfries and at a cost of £232 million.

However, there are so many problems with the operation and design of the new hospital that could have been avoided with more of a direct input from prospective users of the new hospital.

Examples of negative issues that now plague DGRI include:

- No mobile phone signal in the wards and this has proved to be a huge logistical nightmare.
- Parking is totally inadequate and this was obvious from the earliest of planning stages.
- Single rooms throughout will prove to be just as dangerous as many thought it would be – including many of the DGRI staff.
- Simple issues such as the new restaurant/café that is bright and impressive and can seat eighty-seven people, however, not one of those eighty-seven seats has armrests. Who thought that was a good design idea – this is after all a hospital.

The integration of health and social care was long overdue and hopefully the full positive impact that this will have on people’s lives will become more evident in the future but there is still a long way to go.

However, more use of people who use services can help to speed up the process.
Integration, by definition from the Cambridge Dictionary, means “to combine two or more things in order to be effective”.

As we enter the two-year anniversary of integration across health and social care here in Scotland, can we honestly say that it has been successful in doing the above? My answer would be that change is happening, albeit in my area it is incredibly slow and patchy. However there is one area that MUST be taken into consideration that so far hasn’t – but is having a massive impact on both health and social care across not only Scotland but the UK as a whole.

This is the area of “benefits”, or so called “social security”.

As someone who has recently had to access both health and social care services to help me to recover from a prolonged episode of illness, I can honestly say that the support I received was second to none. NHS Lanarkshire, in particular my GP and Clydesdale Psychological Therapies Team, provided me with person centred care, in the right place and at the right time. They worked effectively with each other to ensure that I received what I needed to help me. The Local Authority provided me with support to sort out a complicated financial situation after marriage separation. I also accessed amazing support and opportunities via the third sector in my area. What I will say is there is still very much a sense of the third sector not quite being seen as an equal partner – but that’s nothing new and hopefully will improve in time.

However, all of the support that I received and the incredible amount of hard work I have personally put into my own recovery has been continually jeopardised by the current social security assessment process. I am not exaggerating when I say it was one of the most inhumane and degrading experiences I have ever experienced, ironic given it is a system that is supposed to be there to support people at their time of need.

It is a system that forces you to focus on your illness and your deficits. This alone is psychologically very painful when you are in the grasp of mental illness. Your illness already tells you that you are a waste of space and that this world would be better off without you – and the social security system at present reinforces that message. Prove to us that you are ill – and prove to us that you are worthy of support. To sit in an assessment and be asked by a complete stranger incredibly intimate questions including “why have you not killed yourself” is traumatising.

It is a system that punishes you for self managing, for trying to effectively manage your illness and regain some meaning and purpose in life. It does not allow time for this recovery to happen – it instead assumes that if you can wash your hair, sit without rocking, set an alarm clock and spell ‘world’ backwards – then you are fit for work. Both my GP and Psychologist have been an excellent support to me, composing letters of support as evidence that I am currently not well enough to work. But I know that this is happening every day to people across Scotland – and their medical evidence is being completely disregarded and they are being judged purely on an assessment. The pressure that this is putting on everyone is massive.

So, I would recommend that if we take ourselves back to the definition at the top – that in Scotland we need to add the social security system into the mix because it’s undoing a lot of good work that is happening in health and social care.

Donna, Activist, Campaigner and Volunteer

Include social security into the integration agenda
It’s just two years since health and social care partnerships formally came into being; in many ways, it seems like a lifetime.

Integration of health and care was and is an ambitious (and laudable) aim. I remember listening to a previous health minister (now our First Minister) outlining the Scottish Government’s intentions at a conference over five years ago. She talked about patients not having to tell their story again and again and of a hope that a more integrated health and care system would be responsive, flexible, and focussed on prevention.

That vision drove the third sector’s support for integration as the foundation legislation began its parliamentary journey. That support was dampened however, as the Bill focussed on processes and procedures.

Whilst local authorities and NHS boards would hold all the votes on Integrated Joint Boards (IJBs) in relation to their own services, it was deemed to be a “conflict of interest” for third sector bodies to have a vote. More importantly, patients and carers had no vote and therefore no real say in the services, which deeply touched and connected with their day-to-day lives. That was a huge mistake.

And where are we now? We have a whole new lexicon of public sector speak and another level of bureaucracy which has driven a bigger wedge between people and those who “run” their services. The shape and approach of integration has created less transparency and accountability. Long meetings with reams of papers are not conducive to good decision-making. There is little focus on quality of life outcomes such as reducing isolation – the loss of Food Train in North Ayrshire is an example of this.

Whilst those in more strategic positions than I (after all, I’m just a carer) say that integration is working well, what I see and hear publicly is a focus on outputs and not outcomes. The continued obsession with delayed discharge – whilst important – can drive the wrong behaviours. There is little sense that we are moving towards a more seamless service.

In this context, the NHS gets all the political attention and investment. That’s not necessarily a bad thing. Our universal health care system is something we should be proud of.

However, this louder voice for health overwhelms the role of social and community care services, which retain their “poor relation” status in integrated authorities.

Social care is not valued. The services which provide food, personal care and other vital supports are both life changing and life enhancing. Yet they are procured cheaply, they are not funded properly and were the first to take a hit when the austerity agenda emerged.

They are still being cut, often without any real impact assessment or understanding of the fact that those who are expected to plug the gap are often women who give up their careers and financial security to provide increasing levels of unpaid care.

This poor relation is also in crisis. A whole raft of research from charities like Leonard Cheshire, Carers Scotland and the ALLIANCE portray services which are being decimated.

15-minute personal care visits are deliberately procured by a third of local authorities in Scotland. Waiting lists for access to Self-directed Support (SDS) are not uncommon; families are not being given the choices envisaged by the SDS legislation; and direct payments can be insufficient to meet care or support needs.

Lynn Williams, Unpaid Carer

@Carer49
As the Scottish Government turns its hand to developing a loneliness strategy, eight out of ten unpaid carers feel socially isolated. Difficulties in accessing replacement care contribute to this, with carer health suffering as a result\textsuperscript{23}. Lastly, care homes across Scotland continue to struggle financially – the poor quality of nutrition and the closure of care homes\textsuperscript{24} is the unhappy outcome.

There is, of course, the continued scandal of care charging. A petition to consider the Care Tax has bounced around the Scottish Parliament and in the real world I know families who can no longer afford to pay for care services and associated transport costs.

The care crisis is very real, and we haven’t really begun to consider how free personal care will be extended to adults under 65 (Frank’s Law). The lived experience of disabled people and their families demonstrate the human costs that arise from a political unwillingness to have, as Donald Macaskill says:

”…a grown up non-partisan political debate about what is the real and not the affordable cost of rights-based dignified social care, and not the system we have at the moment…..”\textsuperscript{25}

Families break down; carers become ill and we lose valuable, preventative services, which often enhance the quality of people’s lives. That carers are not really talking about the new Carers Act demonstrates the very real lack of hope or trust in public services or their political masters. Social care is consistently underfunded; new legislation and small pots of money just create complexity and only partially plug the yawning finance gap.

Families I speak to in Renfrewshire and beyond talk constantly about battling for support; they despair when services provided in childhood just stop – with no justification – as their disabled children turn 18. Our own, brief foray into the SDS world had us running into the hills to get away from a stifling bureaucracy which would have left me doing more rather than getting help with my caring role.

Social care is the Cinderella (in her rags) public service. It cannot compete with the attention surrounding our NHS. We cannot continue to build care and support services based on the lowest price possible.

That is the challenge for Integration Authorities as we move into year three. How do we ensure that social care is treated with more love and compassion and that it is afforded the value it deserves? How do we ensure it enjoys greater parity and a cross party debate about how to better fund it?

Tinkering at the edges of social care is no longer enough and Integration Authorities and Ministers need to look beyond political cycles and think big, alongside those of us who rely on both health and care services to live our lives. Too many lives depend on this. To keep our collective heads in the sand about this poor relation is to say that our families are not worth fighting for.
The views of an integration authority patient representative

Margaret Moncrieff, Chair, South Lanarkshire Health and Social Care Forum

As the Public Bodies (Joint Working) (Scotland) Act 2014 did not have a legal obligation to include the Public Partnership Forum – only stating that there should be a patient representative on the Integrated Joint Board – I felt it was important that this representative was supported by a strong organisation.

To this end, the then Public Partnership Forum began work, facilitated by Scottish Social Services Council (SSSC) and NHS Education Scotland (NES) and supported by the South Lanarkshire Health and Social Care Partnership (SLHSCP) Organisational Development Team, to set about responding to the new arrangements brought by the Act. This resulted in the change of name for the Forum to send a clear message that their role had changed to include social care.

The Forum then produced a new Working Agreement and associated papers and the Working Agreement was signed by Val De Souza, Director and Chief Officer, SLHSCP, Calum Campbell, Chief Executive, NHS Lanarkshire, and myself as the Chair of the South Lanarkshire Health and Social Care Forum.

Following a report to the Integrated Joint Board (IJB), the Forum was appointed as the “Community’s Voice” for this work.

What is working well

Integration has encouraged more “partnership working” with many more joint health and social care initiatives. In South Lanarkshire, the Integrated Community Support Team consists of health and social care staff who support patients to remain in their own communities and offer a coordinated approach to their care. There is a similar approach with the service provided by the Hospital at Home Team, preventing hospital admissions and enabling patients to remain at home even when they have high care needs.

Integration has also encouraged more joint training between health and social care staff and enabled them to have a better understanding of how they work together. Training for IJB members has also offered them a better understanding of their individual roles and responsibilities; a shared understanding of integration; and how the IJB’s work relates to the Health Board and the Council. Forum members have also had the opportunity to participate in joint training where appropriate.

The Forum’s members’ involvement in the Building and Celebrating Community events throughout South Lanarkshire; the Strategic Commissioning Planning process; the Locality Planning Groups; the implementation of the new GP Contract; and many other initiatives have ensured that the public have a meaningful voice in truly influencing the planning and consultation process.

I initially had concerns that my voice would not be valued as I did not have any voting rights, however this has not materialised. Instead, senior staff within the Partnership have promoted our involvement in this process resulting in discussions taken at IJB meetings that have made a change in process and support for patients in several sensitive situations.

An initial protocol has been agreed for issues and concerns from the community to be “fed into” the integration process and for the Partnership to cascade information to Forum members. Following a gap analysis, it was highlighted that the Forum has a circulation of almost 100,000 people which is almost a third of the population of South Lanarkshire.
What is not working

My main concern is the uncertainty of funding and support for unpaid carers due to:

1. The responsibility changing from one NHS Board to two Partnership Boards, one of which is currently undergoing a commissioning process especially when most of the care for unpaid carers is provided by a carers organisation which covers both Partnership areas.

2. The development of a Community Capacity Building and Carers Support Strategy in North Lanarkshire that does not take account of the major role of the Lanarkshire-wide Carer Organisation.

3. The increased workload associated with the implementation of the Carers (Scotland) Act 2016.

I hope most of these issues can be resolved soon to enable the focus to be on taking forward the recommendations in the Carers Act and ultimately providing a better a more coordinated service to unpaid carers.

What would work, if only we could...

- Have more finance
- Improve communications by all involved in this process, including between patients, carers and staff and between staff from the same or other organisations
- Decrease the time to implement packages of care
- Have a system for all patients and carers to enable them to access one person who could coordinate all their care services instead of having to give the same details to various members of staff
- Have an IT system that covered primary care, health and social care
- Build trust between the statutory, voluntary and independent organisations.

I believe we are on the right track, however there is still a lot of work to do to encourage the integration process across all services, staff and the public. To promote change is a challenge, but all involved have an important role to play in promoting this approach.

Further information is available at www.slhscp.org.uk, with a link to “Get Involved” for more information on the South Lanarkshire Health and Social Care Forum.
People First (Scotland) works for the human rights of people who have the labels of Learning Disability or Intellectual Impairment. Members of People First spend a massive amount of time looking at ways to challenge poor service provision but also working proactively to offer lived experience, insight, expertise in the design of systems and services. We campaign to establish and protect the same freedom, choice, dignity and control held by other citizens across all areas of life.

The integration of health and social care should or could offer a balanced and whole person approach to meeting support needs. The ambition to develop health and social care systems that really work together, delivering a joined-up service is a positive one. Indeed, we regularly campaign for better support and effective communication about and within it for people with a learning disability.

However, it is hard for us to talk about integration as a concept without talking about member experiences of health and social care in general. The idea of health and social care integration was to improve these experiences and lead to better outcomes but, so far, this has not been the reality for our members.

Within the People First (Scotland) membership we have struggled to find members who have experienced positive change to either the support or the healthcare they receive since integration came into place.

Over the years we have heard lots of different names for support that we might get offered, or the way that plans and payments are put together for support we do or do not end up getting.

These include self-directed support, day options, residential support provision, support for living, individualised support, personalised support, support at home, home care, tailor made support, person-centred support and community care, to name a few.

Often large changes have happened without us being usefully consulted, informed or involved.

Each time that support has been organised differently, or called something new, we have had to deal with a period of change and uncertainty in our lives. We have been through this many times but it does not make the process any easier.

Almost without fail, a change in name, in approach or department has meant that the amount of time on offer, or the availability of the support, has been reduced. Across Scotland, members report that their support is being cut and they are forced to make difficult choices. The choice between support to buy food, support to pay a bill or support to see the doctor. The idea of using support creatively or flexibly simply does not exist for many of us.

We are assessed using eligibility criteria designed to recognise and respond to loss of skill and deterioration rather than our level of need. But it should not matter whether someone requires two hours or 24 hours of support. What we need is support that allows us to live a full and varied life like other members of society. We want to learn, to work, to live as a family, to contribute, but we need fair and equal access to health and social care to make that happen. There are still very few occasions where the real and useful range of support, required throughout life, is on offer.

It is still the case that the structures and processes for most service planning continue to
change and proceed without our involvement.

How about starting with the information about services for health and support being offered first of all in an accessible manner? ‘Alternative versions’ can provide less accessible or more specialist information with the expectation that support to access that will be on offer.

We need services that communicate with each other and work in cooperation rather than in isolation. The experience shared by People First members tells us that this reality is still a long way from being realised. People with a learning disability are still living in hospitals because there is no support package in place for them to live in the community. Calling somewhere a unit rather than a ward does not change this.

So, what we share here is frustration. Whatever you call something, it is the life experience of Scottish citizens that shows whether things are right, whether things are working, changing, or heading back towards mistakes made previously.

If there is no expectation that support allows a life, an independent life, with all the ups and downs that brings, then calling what is offered integrated, person centred, or anything else makes no difference. The fact is that people with a learning disability continue to experience poorer outcomes than the rest of society.

What we need is to be involved in planning and decision making. What we want is genuine involvement in decision making, at all levels. This could mean people with a learning disability sitting on IJBs, with those meetings taking place in an accessible way, facilitating meaningful participation. It could mean other, very local planning solutions, but it certainly means Nothing About Us Without Us.

It means politicians and disabled people’s organisations working in co-production to come up with long term solutions that meet the needs of those who use these services.

Finally, and crucially, we need long term investment in health and social care rather than the ongoing reductions in service that we continue to experience. Without that commitment to funding, people with a learning disability will continue to lead poorer, unhealthier lives, will continue to die younger than other citizens, will remain excluded not integrated in so many ways.
The views of an integration authority carers’ representative

Sue Beer, former Carers’ Representative, Shetland Islands Integration Joint Board

In addressing my views on health and social care integration, I am focusing on my previous role of acting as a stakeholder representative on our local joint Integration Authority, and noting improvements that have developed over the life of the authority.

Until February 2018, I was the carers’ representative on the Shetland Islands Integration Joint Board (IJB); fortunately, we were successful in recruiting a new carers’ rep since I ceased being a carer in February 2017. I have been actively encouraged by the IJB Chair and Lead Officer to mentor the incoming representative, and attended seminars and IJB meetings with him as well as personally ensuring that he can contact me with any queries.

I joined the Community Health Partnership Committee of the Shetland NHS Health Board in 2011 as Carers Representative, sponsored by the then Shetland Carers Link-Group, now Shetland Carers Strategy Group. I was fortunate to have received training for this role, with other Scottish carer representatives, from Marion McParland, then of the Scottish Government Carers Policy Unit, and Claire Cairns of the Coalition of Carers in Scotland. When the IJB started up, it was agreed that the three then stakeholder representatives from the CHP be retained.

I am now a substitute, for both the Carers and the Third Sector representatives to the IJB, should either rep be unable to attend (I work for the local Third Sector Interface). I get the papers electronically for all the meetings, but only get printed papers when it is known in advance that I will be attending; I am also invited to attend the seminars and other knowledge sharing events. This means that when the normal reps are unavailable, someone is going into the meeting who has the knowledge and experience both to ask relevant questions and to feed back to their stakeholder group. Official substitutes are also in place for voting members from both the Local Authority and the Health Board. This recognition of formal substitutes is a useful improvement on the earlier process, where substitutions were requested formally through the chair on a meeting-by-meeting basis, giving the name of the person who would be the substitute and officially requesting from the Chair that they be allowed to attend when absences were known in advance. It is particularly useful for carers’ representatives, as carers tend to be on call 24/7 and can rarely guarantee availability.

Membership of IJB voting members has undergone a great deal of change; only one of the three health board members (the current Chair) has been in place since the Board’s inception; none of the local authority members predates the 2017 local authority election. The public/service user representative slot was unfilled for over a year; the previous incumbent (who volunteers for a number of public roles) found that the quantity of reading required in preparation for the meetings was too onerous.

For stakeholder representatives; where both attendance at meetings and keeping up with papers is not a role for which they are remunerated, this can be a very time-consuming consideration. Again, we have improvements in place; there is an understanding that we do not have the same facilities for printing out papers so we are furnished with hard copy, but we do not have the same iPads that the majority of members have as part of their employment. I have ensured that there is a proper system in place for the reimbursement of travelling
expenses for the incoming carers’ rep, as this had not been previously addressed.

Some stakeholder representatives have voiced their concern that not having a voting role on their integration authority means that they do not have a proper voice. For me, I felt that not having that responsibility was quite liberating, and in any case, there is the expectation (not always realised) that there will be a consensus.

As a carers’ representative I have also been invited to meetings of the ‘Carers Collaborative’, developed and facilitated by the Coalition of Carers in Scotland; this is a national forum for IJB carers’ reps where peer support and the sharing of good practice has helped to strengthen the representation that we can provide.

In common with other carers’ reps the extent to which individual carers’ views and needs can be taken forward to meetings is limited, but what is critical is that, in the consideration of policy and service provision, carers’ needs in general are catered for and that carers are included in strategy documents; I see this as the main role of the carers’ representative. Some carers’ reps have a place on their IJB’s agenda committees; we have no such committee, and until recently had no mechanism for adding items to the agenda, but we do now have the opportunity, when reviewing the forthcoming Business Programme of the Board, to ask for the inclusion of germane agenda items at future dates.

The final improvement in my time that I would like to highlight has been our current Chair’s public statement that all members, whether voting or non-voting, have their part to play in the board meetings, and that as well as representing their designated interest they have a proper role in questioning and commenting on any matters that come before the board.
Planning integration services for the future – are we in danger of missing an opportunity?

Alison Keir, Policy Officer – Scotland, Royal College of Occupational Therapists

Occupational therapists work across agencies, therefore integrated working is key to our success. The core training of occupational therapists includes both physical and mental health skills – this dual role makes occupational therapists ideally placed to work with the “whole” person to help them achieve what is important to them. Occupational therapists have always worked in health and social care settings with adults and children of all ages with a wide range of conditions; most commonly with those who have difficulties due to a mental health illness, physical or learning disabilities.

Occupational therapists in Scotland have differing experiences of integration. In some areas there has been significant work to review current occupational therapy practice and there is good learning from this. In Glasgow, the outcome of the review ensured that there was no duplication of services for people, with occupational therapists being employed in different roles across systems. Core competencies have now been developed in Glasgow to help standardise care and onward referrals – this was made possible through more integrated ways of working. Regardless of area of work, all occupational therapists have the same undergraduate training to equip them to work in both health and social care and thus are uniquely placed to contribute to the integration agenda.

Occupational therapists support people to remain at home and in their communities by working with the person to improve their confidence and abilities to continue with occupations through the use of strategies, techniques, and equipment. Increasingly the evidence supports working with people earlier, as we know that this helps them maintain function and to self manage. Occupational therapists are experts in assessing the person’s abilities to help them to manage to safely remain at home, reducing the length of hospital stay and delaying the need for residential care.

The “Lifecurve” work stream of the Scottish Government’s Active and Independent Living programme (ALIP) clearly demonstrates this need for earlier intervention when people first have difficulties with everyday tasks, and therefore endorses the need for earlier referral to occupational therapy, and to support Health and Social Care Partnerships (HSCPs) to keep people in their own communities. Traditionally, referrals to occupational therapy tended to be made once people were struggling or in crisis, but we must make better use of our occupational therapy resource across HSCPs and make earlier referrals to occupational therapy. By using services earlier, when people are able to make maximum functional gains, we will support people in a more appropriate way to self manage, have better health and wellbeing outcomes, achieve personal goals and will use resources more efficiently.

Increasingly, occupational therapists are working with different partners such as Fire and Rescue Services and the Scottish Ambulance Service. By working in partnership, occupational therapists are using their skills to work with others to prevent admissions and to reduce risk. Occupational therapists have the skills to support Primary Care services and by working...
We Need To Talk About Integration

more closely with GPs, such as the pilot project in Lanarkshire, we are able to work with people who would benefit from occupational therapy much more quickly, which has been shown to produce better outcomes.

Occupational therapists are working with communities to help them develop their skills to support residents locally. For example, this might be working with teachers by providing training packs to help improve motor or social skills, or it might be supporting staff in care homes to run groups to decrease isolation. Such training provides quicker access to universal support for more people whilst freeing up and reducing waits for occupational therapists to provide very specialised interventions. The emerging possibilities for technological solutions to support people to stay safe and independent are also assessed for, trialed by and supported through occupational therapists. One example is the looking gas cooker valve which prevents a gas cooker from being unintentionally turned on or left on.

Occupational therapists have much to offer, and the skills and experience to lead transformational change. As such, we must be considered key players in service planning. Occupational therapists should be at the table to help inform and drive the direction of future travel rather than be asked to consult on decisions made by others on what they believe occupational therapists can offer. This is a missed opportunity. Occupational therapists welcome integration and embrace the opportunity to continue to improve services to ensure improved health and wellbeing for people living in Scotland.
This year public services in Scotland enjoy a couple of milestone birthdays, with the National Health Service turning 70 and Social Work celebrating 50.

Anyone with a broad interest in the history of the welfare state, set up to tackle Beveridge’s five giants of “poverty, disease, ignorance, squalor and idleness”, will enjoy looking back at the public good created by these hugely ambitious reforms.

Those of us who have been privileged to work on a more recent innovation, integration of health and social care, are also reflecting on progress: seven years have passed since the 2011 Scottish election that saw cross-party support for integrating health and social care, and it’s now four years since the Public Bodies (Joint Working) (Scotland) Act 2014 was passed by the Scottish Parliament. What does progress look like since 2014?

Integration is one of the most significant reforms since the establishment of the NHS, largely because there has been such progress in wellbeing since the 1940s. It’s also a tremendous opportunity to bring together and learn from the best of different expertise and cultures across public services and beyond, and across communities.

In Scotland, we’ve based our approach to integration on a handful of key principles:

- Health and social care services should be firmly integrated around the needs of individuals, their carers and other family members;
- Services should be characterised by strong and consistent clinical and care professional leadership; The fact that we need to integrate health and social care is, of course, a challenge, but it’s also a cause for celebration, reflecting as it does the longer, healthier lives we generally enjoy.

Providers of services should be held to account jointly and effectively for improved delivery; and

Services should be underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve rather than the organisations through which they are delivered.

Around these core ideas we have built requirements on existing agencies – Health Boards and Councils – to pool their resources and expertise, to share opportunities and risk, to maximise their joint contribution to the wellbeing of the populations that they serve, and to ensure a meaningful role for communities in deciding on services that are appropriate to local priorities.

We have created a new type of statutory body, Integration Authorities, so that people and resources are not only brought together but also empowered to act – to plan and spend – differently and better, to meet and anticipate Scotland’s changing health and social care needs.

We have created new roles, particularly those of Chief Officers and Chief Finance Officers of Integration Joint Boards, which set out in statute responsibilities that were previously held separately and sometimes at odds with one another.

We have set out in law requirements for the role of third and independent sector partners and for clinical and care professionals.
We Need To Talk About Integration

Perhaps most ambitiously, we have set out that budgets for complex care – spanning communities and unscheduled care in hospitals – must be pooled to maximise their impact and to support our long-held ambition to shift the balance of care.

All of this is naturally disruptive – deliberately so – and sometimes uncomfortable and difficult. But is it starting to make a positive difference?

Yes it is; we are seeing progress in terms of improvements in care. Over winter, always a litmus test for health and social care, we have seen Integration Joint Boards make a material contribution to the quality and sustainability of care, particularly in terms of sustaining social care performance and maintaining the trend in reductions in delayed discharge from hospital. The wellbeing of the country is not to be measured only in terms of service statistics and pressure on hospitals, but these are helpful indicators that things are moving in the right direction.

Are we there yet? No we’re not; not yet, but we are making progress.

When the Scottish Government’s consultation on integration was launched in May 2012, the First Minister, in her then role as Deputy First Minister and Cabinet Secretary for Health and Wellbeing, said:

“It is our intention that the integrated resource should lose its identity in the integrated budget – so that where money comes from, be it “health” or “social care”, is no longer of consequence. A practical example of the effect we are looking for is that [Integration Joint Boards] will be able, for example, to spend what is currently categorised as “health” money – used to pay for, say, district nursing – on “social care” activity – to pay for care at home services, for example – or vice versa.”

An honest assessment shows we still have some distance to go on that, despite the progress so far.

Localism – the opportunity for local voices to contribute to decisions and the empowerment of local systems to make the right decisions for local communities – is key, and is built in directly to the mechanisms we have created to support integration. The Christie Commission Report on the Future Delivery of Public Services in Scotland (2011) noted that “effective services must be designed with and for people and communities – not delivered ‘top down’ for administrative convenience”: another example of an ambition towards which we’re making progress, with further yet to go.

So, progress? Yes, with large and small gains all the time in terms of stronger relationships in local systems; in terms of better quality and more sustainable care delivering better outcomes; and in terms of recognising that joined-up care is a partnership effort, with shared leadership, shared opportunities, and shared risks. Further to go? Yes of course – but with 120 years’ combined expertise across health and social care on which to build improvement, and clear commitment from the Scottish Government to ensuring the success of integration, every reason for optimism.
Integration – a public health perspective

Cath Denholm, Director of Strategy, NHS Health Scotland

If the Faculty of Public Health defines public health as “the science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society”, then the aims behind health and social care integration are public health aims.

People’s experience through every public service they receive has an impact on their health and wellbeing. The more that services are joined up to meet a whole person’s needs the better. The more that services are measured on how they keep people independent and well (rather than the extent to which ‘beds are blocked’ or ‘waiting times exceeded’) the better. And, lastly, the more that people’s needs – both at individual and population level – are understood, the easier it is to plan and deliver the most effective kinds of services. So yes, public health is a big part of health and social care integration.

Two years on, does this mean that health and social care integration is providing public health benefits? Are health and social care services contributing to reducing health inequalities (National Health and Wellbeing Outcome 5)? Are health and social care services centred on helping to maintain or improve the quality of life of people who use those services (Outcome 4)?

You’ll have your own answers. From my perspective, which I’m conscious is national rather than local, it would seem that the overriding focus of health and social care services is currently on meeting ill health needs.

Can public health do something about this? It must. Some public health and population approaches will never be aimed at health and social care services. However, public health can definitely contribute more to managing demand and delivering the national outcomes of health and social care.

Prevention must become a more integrated part of thinking and practice. Routine enquiry into gender-based violence during maternity care is an example with some success. Just as the referral pathway for recurrent urinary tract infection is mainstreamed, we need to make it as easy for primary care practitioners to routinely refer people into practical support to deal with issues like fuel poverty, financial problems, or social isolation – issues that fundamentally affect people’s health and wellbeing.

Public health data, analysis and interpretation offers real impact in planning the wide variety of patient pathways we need to protect and improve health. To do so, it needs to be accessible and more simply communicated to service planners, providers and people using services. There are many underlying factors, such as alcohol, deprivation, obesity and people with multiple conditions, which affect Scotland’s health and how long people live. Providing evidence-based scenarios to help service planners steer resources to where they are most needed will help manage demand and help achieve sustainable services into the future.

But while improving population approaches is
We Need To Talk About Integration

extremely important, it is not the whole story.

I believe very passionately that public health also offers a framework to ensure effective inclusion of people, person by person. For me, any ambition to improve health and eradicate health inequalities is fundamentally underpinned by a human rights based approach. That means services which involve the person and which are founded on the fact that people have a right, not a privilege, to what sustains their health. Service transformation, including new digital technology, is currently a big focus of making services more efficient. That’s fine, but I also want to see more about basic human need. Take the example of a man in his seventies having multiple falls at home. Health and social care integration is probably well set up to organise services such as bone scans, home assessments for aids and so on – though there may be waiting times and communication breakdowns between services to contend with along the way. But what if the primary cause of his falls is that he is drinking too much, which is directly related to his grief and isolation because of the death of his partner? That’s a broader lens through which to view the pathway of his support and a broader lens for integration of services.

We won’t get services that are based on underlying need, and are sensitive to the points in people’s lives where they are most vulnerable, without the right to health being absolutely core to delivery values. Some of that is in planning. Some of that is in workforce development but, crucially, also in the workforce capacity within health and social care to have the time to take that approach and live up to the values in the health and social care legislation outcomes.

At this point, governance and structural issues still seem to dominate health and social care integration. Once we get beyond this point to a phase of genuine cultural change, public health – in its breadth of what it knows and says about the financial and social determinants of health, power, the health of the workforce, and much more – will be in a better position to help health and social care integration achieve the ambitions of the nine Health and Wellbeing Outcomes set out in legislation.

Public health needs to be ready when health and social care integration is ready. Scotland’s current public health reform agenda brings an exciting opportunity to reframe the relationship between acute, service-based care and systems that create and sustain a population’s health and wellbeing. Some of this may mean aspects of public health becoming more integrated into health and social care services in the future. It is also likely to mean public health’s voice being put to most effective use elsewhere. It will certainly mean realising the potential of public health leadership, and it will certainly mean broadening out what we mean by the ‘public health workforce’ not just to health and social care, but also very firmly to the third sector. It is certainly the time to be thinking about this, in order to get it right.
Introduction

At the time of writing, partners in East Ayrshire are developing the Strategic Plan for 2018-21 – some feelings of déjà vu and much to reflect on.

Purpose is central to strategic planning. A policy coherence around health and social care interdependency has emerged over time and integration has a substantial history, especially since 1997\textsuperscript{26}, finding ultimate expression in the Public Bodies (Joint Working) (Scotland) Act 2014.

The 2014 Act requires integration authorities to:

• prepare a strategic plan for delegated functions
• work to national health and wellbeing outcomes
• plan and deliver to underpinning integration principles
• expect that partners will be involved in planning for wellbeing
• consult with defined partners in developing plans
• develop supporting locality arrangements.

The focus is on improving resident wellbeing at individual and population level through prevention and anticipation.

Vision

Strategic planning is often seen as either ‘top-down’ or ‘bottom-up’. It is both. There is a need to identify drivers of change to set strategic direction, while leaving room to engage and adapt.

Creating a compelling shared vision is a key factor. The Strategic Planning Group (SPG) role is fundamental. In East Ayrshire, the SPG developed from the Community Health Partnership Forum and transitioned with minor membership change, preserving continuity. This history of working together is critical to having respectful, honest conversations and openness when considering alternatives.

The SPG is instrumental in developing the long-term perspective of the Health and Social Care Partnership (HSCP) and how partners work together toward this. The shared vision expresses the drive to work with, and be led by, communities to improve wellbeing and promote equity. This vision aligns with the sovereign Community Plan vision of strong, vibrant communities\textsuperscript{27}. The Wellbeing lead for the Community Plan sits within the Integration Authority and involves wider partners. E.g. Police Scotland, Scottish Fire and Rescue Service, Housing, and Education Services.

Values relate to those of the parties to the Integration Scheme and those unique to integration. These speak to integration principles of safety, dignity, respect, seamlessness, and quality – how we support wellbeing.

Needs/Assets

A demonstrable case for change is made through needs assessment, analysis of demographic drivers, poverty-related multiple conditions and constrained resources\textsuperscript{28,29}.

Strong relationships between health and social care, the Third Sector Interface, independent sector, housing, public health, Vibrant Communities, the Health Council, the ALLIANCE, and other partners generate ownership of priorities and actions.

We produce meaningful, accessible, ‘living’ plans. This has resulted in visualisation of needs assessment, infographics and a ‘Plan on a Page’. Our Plan includes workforce, choice and control, technology enabled care and community engagement as key enablers.
Collaborative annual review is a strength of the local approach. The Act requires consideration of the need for a ‘replacement plan’. Review has facilitated horizon scanning and taking stock of positive practice. This has assisted in adapting to change and presenting the Plan alongside an integrated budget.

**Engagement**

The 2014 Act continues the Christie Commission direction: “public service organisations should increasingly develop and adopt positive approaches which build services around people and communities, their needs, aspirations, capacities and skills, and work to build up their autonomy and resilience”.

Integration principles reflect this. In East Ayrshire, a Participation and Engagement Strategy is in place prepared with the SPG. Public engagement takes place through Big Plan Days, Local Conversations, Localities and Community Action Plans. Engagement across partners and the workforce provides opportunities to discuss the vision and what it means in practice. Energy and vibrancy is brought to engagement through showcasing community talents.

**Outcomes Approach**

Integration is not solely about achieving policy outcomes, it is about personal outcomes. Integration is about making sure that people live in their own communities and do not spend longer than necessary in hospital or any institutional setting. Fundamentally it is about experiences and outcomes for people – the ‘what matters to you?’ question.

Our framework incorporates health and wellbeing, children and families, and justice outcomes reflecting delegated functions. An outcomes-focused approach runs through the partnership, as demonstrated in the case for change in our first Strategic Plan. This provides ‘before and after’ illustrations of the benefits of integration, developed by members of the SPG. Outcomes form a common language through Getting it Right for Every Child and Talking Points.

**Locality Planning**

Integration principles require taking account of the needs of different areas. Localities are critical, providing stakeholder and professional ‘voice’, with the expectation of having significant strategic influence. The policy intention is of localities as the ‘engine room of integration’.

Three localities are in place in East Ayrshire covering an average population of 40,000 with natural variation across our town and rural communities. Localities are formed around Multi Member Wards, maintaining the link with Elected Members. Community Planning Partnership and HSCP localities are coterminous. Locality working is based on co-production with localities undertaking needs assessment to identify priorities, mapping community assets and highlighting activity to improve outcomes. Chairs of Locality Planning Groups attend the SPG.

The key is to establish dynamic links between locality and strategic fora. Participatory budgeting is a means to build commitment to Locality Planning.

**Performance Reporting**

In reporting performance against national outcomes, we work to national guidance on the Integration Indicators while also giving life to performance through case studies of local practice, events, and engagement. Performance reporting includes accessible ‘road map’ and infographic visualisations alongside detailed reporting. We share practice through Pan-Ayrshire work and other networks.

**Conclusions**

- Our approach to strategic planning is serving us well
- There are significant challenges arising from the socio-economic and financial context
- Partners recognise the need to strike the right balance between prevention and early intervention and integrated care and support
- We would expect to return to the question of how far localities have become the ‘engine room of integration’ in future
- There are stages in change and continued deepening of integration requires both patience and perseverance
- Positive relationships and commitment will be key to transformation over 2018-21.
The Christie Commission, published in 2011, set out the challenges facing our health and care systems. It challenged us to overhaul the top-down relationships of our traditional, complex and fragmented, system to a new order of integrated collaborative partnerships. It recommended building systems of care from the bottom up in a co-productive approach between multi sector resources and communities, supporting and building resilience and realising assets and talents. It was the birth of what we now call Health and Social Integration. In the two years since integration there has been significant energy around governance and fiscal arrangements in the strategic "sunlit uplands" of regional authorities but what effect is this having down the line? This article takes in the view as seen from the relative "swampy lowlands" of General Practice.

General Practice has traditionally seen itself as a holistic resource that looks beyond the biomedical concerns of people to embrace the social and emotional contexts of wellbeing. However, if we are honest, the shifting nature of GP caseloads has threatened the holistic essence of family practice. This workload shift includes the ever increasing medical and technological responses to illness; contractual guidelines for long term conditions; and sicker, older and frailer people being cared for at home. Practice, if anything, has become more reactive, with, frustratingly, less space for proactive planning. The personalised approach of Dr Finlay has being replaced by a more industrial model. However, GPs have long recognised that the "pill for every ill" approach is limited, unsustainable and a soulless way to practice medicine, not to mention for those on the receiving end.

In this respect, the concept of integration and its ethos has been broadly welcomed by GPs. However, it has created numerous challenges to overcome before we can all arrive at the well functioning health and care "Nirvana" envisaged by Christie.

Multi-agency working is a complex process of communication and relationship building, which takes time along with new collaborative leadership skills, attitudes, and opportunities. This can challenge mindsets and systems, which have been hard-wired to previous ways of working. Team working can complicate communication, action, and continuity of care. IT may help all this, but systems need to join up and talk to each other, mindful that they must promote rather than replace relational care. It's also a big change for individuals and communities with an expectation that it's in their best interest that they become active partners rather than passive recipients of care and services. Encouraging and supporting them in this new role is hard and takes time, being aware that people differ in motivation and capabilities. How we respond to these differences is key.

Welcome initiatives are aligning themselves to support General Practice with integration. Leadership support and training through the "You as a Collaborative Leader" initiative developed with the Scottish Social Services Council (SSSC), NHS Education for Scotland (NES) and RCGP Scotland has been insightful. The ALLIANCE-led House of Care Scotland Programme is helping practitioners and their
We Need To Talk About Integration

patients living with long term conditions to proactively plan care together, in ways that support people to self manage. These conversations are a crucial mechanism by which we identify the needs of individuals and are therefore critical to informing how our health and care system responds. The Links Worker Programme and the ALISS project are helping us to understand how we build connections, knowledge and partnerships with community based self management support. The new GP contract is set to encourage multiagency collaborative working. Data gathering and sharing is looking promising. Developments such as Scottish Primary Care Information Resource (SPIRE) and the support of NHS Information Services Division (ISD) ‘Local Intelligence Support Teams’ will be invaluable. It’s important to recognise that beyond these national initiatives there are many good examples in General Practice of local collaborations.

The learning so far is that it’s all going to take time before we see measurable change. At the moment few of us have the vision or understanding of what integration and its benefits could look like. There is a worry that GPs and their teams will struggle to find the time and capacity for the necessary leadership to move from their current, entrenched systems and structures. Promoting a more social model of care will also need investment and a courage to shift money and resource beyond traditional “services”. Whilst fiscal restraint may be a driver for integration it will not facilitate it. It will require those who hold the budgets and control to listen to, trust, support and empower local teams who are delivering services in order that those local teams can reciprocate with the individuals and communities that they work with. It’s all about relationships and how we facilitate them. Examples of it working well can be seen in practices co-located with care professionals and support workers, with frequent formal and informal meetings and “virtual ward rounds”.

I remain optimistic that Scotland, with its communitarian and rights-based ethos, manageable size, and dedicated workforce, is well on the road to maximising the benefits that integration will bring.
Both the Public Bodies (Joint Working) (Scotland) Act (2014)\(^{38}\) and the World Health Organisation’s ‘Strengthening a Component Health Workforce for the Provision of Coordinated / Integrated Health Services’\(^{39}\) position the integration of health and social care services as the principal means of transforming the delivery of services.

In relation to staff, the Scottish Government’s 2017 National Health and Social Care workforce plan\(^{40}\) acknowledges that planning for the future NHS Scotland workforce will require a broad range of professionals who recognise that inter-dependence, the importance of ‘whole of workforce’ and a distributed model of professional leadership will support the provision of more sustainable services.

From an international perspective, the WHO, citing Frenk et al, notes the importance of:

> “all health professionals in all countries to be educated to mobilize knowledge and to engage in critical reasoning and ethical conduct so they are competent to participate in patient and population-centred health systems as members of locally responsive and globally connected teams”\(^{41}\)

All this highlights that delivering integrated care across the globe requires the workforce to be appropriately educated. At the University of West of Scotland (UWS) we have responded to this need by developing undergraduate and post graduate programmes in integrating health and social care. These have been developed to address the educational needs of a cross-sectoral health and social care workforce in cultural transformation, focusing on educating for enablement and empowerment through co-production and an asset-based approach.

The programmes we deliver at UWS are the BA (Hons) Integrated Health and Social Care\(^{41}\) programmes – which have been successfully running since 2011 – and the more recently validated MSc in Leading People-centred Integrated Care\(^{42}\). These programmes are reflective of three stages of education as identified by Frenk et al:

- Informative education – the acquisition of knowledge.
- Formative education – socialisation into work/profession.
- Transformative education – preparing to be leaders and mobilising knowledge positive values.

The UWS undergraduate programme is focused on informative education and the post graduate on transformative education. The ethos behind both is to enable and empower the students to deliver, develop and lead integrated services in order to promote and enhance quality, effective and efficient people centred services.

The undergraduate BA programmes develop the graduate skills required for the changing landscape of health and social care. This includes study of the policy, practice and factors that influence integrated service provision; person-centred service delivery; professional, leadership and management skills; evidence-based solutions.
We Need To Talk About Integration

and research principles; and reflective practice that fosters a values base of rights and respect for all.

The postgraduate MSc is designed to provide a progressive pathway for staff working in the cross-sectoral field of health and social care. The core modules are built around the five strategies identified within the WHO’s Framework on Integrated People-centred Health Services. This includes the exploration of creating the conditions for integrated care; engaging and empowering people and communities; leading and transforming cross-sectoral services; and ensuring value for people, professionals and organisations.

A key feature of the programmes is that, through the multi-professional and multi-sectoral nature of shared co-productive learning to integrated care education, students can explore the complexities and challenges of delivering and leading system integration. This is advocated as a way of breaking down professional boundaries and in developing a more cohesive approach to professional practice. This allows shared and asset-based learning to take place between the diverse roles of the students and staff, in addition to the impact on the cultural appreciation and shifts that are required to ensure the delivery of integrated, person-centred services. This is supported with the use of Appreciative Inquiry to support transformational change.

The principle of co-production is evident throughout both the ongoing developments in the undergraduate programme and in the development of the Masters programme. Both programme teams have been commended for the co-productive approach taken, which has included subject specialists in integrated care, students and programme staff. Delivering and developing programmes relating to integration cannot be done in isolation and must uphold the very principles of integration it is aiming to achieve.

The portfolio of programmes at UWS has been built from experiences of staff delivering the undergraduate programme and provides opportunities for shared, cross-sectoral and boundary spanning learning using both a bottom up and top down approach to teaching and learning in supporting the cultural shift and transformational change that is required to ensure the delivery of truly people-centred integrated care.

If you would like more information about the programmes please contact:

BA (Hons) Integrated Health and Social Care: Elaine Gifford (Programme Lead)

✉️ elaine.gifford@uws.ac.uk
📞 0141 849 4325

MSc Leading People-centred Integrated Care: Helen Rainey (Programme Lead)

✉️ helen.rainey@uws.ac.uk
📞 0141 849 4323
For most Integration Joint Boards (IJBs), April 2018 marks the 2 year anniversary of our ‘going live’ as new organisations and publishing our Strategic Plans, which set out how we’d deliver change though our Health and Social Care Partnerships (HSCPs).

While our ‘go live’ was an important milestone, we did recognise that it really marked the beginning, and not the end of the challenges ahead - of not only integrating significant elements of two organisations, but in relation to the wider, and longer term transformation of health and care services across Scotland. That’s an enormous task and one that we continue to put huge effort into achieving.

So, in the two years since going live, what have we achieved in the new integrated partnerships and what’s yet to be done?

What were we set up to do?

Integration, as a policy, set out to do nothing less that shift the balance of care and transform the health and care system in Scotland. We were set up as IJBs and HSCPs to achieve a number of things:

• Develop seamless, person centred health and care services and ensure that people don’t feel the join and can navigate them easily, accessing what they need, when they need it and which are based on self-care, and care as close to home as possible.

• Support and sustain thriving and innovative primary and community care services, which are truly multi-agency and multi-disciplinary in their nature.

• Creating, through the development of localities, a move towards community empowerment and participation in planning for health, social care and wellbeing.

• Tackling long standing health inequalities and improving health and wellbeing.

• Sustaining service provision that’s safe and effective and delivered as close to home as possible while managing the challenge of our changing demography and the increase in complex multiple conditions and frailty.

• Work in partnership across all agencies that support health and social care.

We have a huge task in front of us still but in Aberdeen City we’re also hugely ambitious about the potential to transform our services and our plans set out those ambitions and the change we aspire to make.

What have we achieved?

Aberdeen HSCP has an agreed and broad ranging transformation plan in place. This sets out the six ‘big ticket’ change items that we’re focussing on to help us achieve the shift in the balance of care, and the outcomes we want to see. There’s not space here, but if you’re interested you can find much more information about our IJB, our performance and our plans on our website at www.aberdeencityhscp.scot.

Through the work we’ve been doing, I believe we can point to tangible change and improvement in a number of areas and I’ve set these out below:

• We’ve delivered a sustained and significant reduction in the number of people who have been delayed in an acute hospital setting and
who are ready to go home – known as Delayed Discharges. We’ve seen an almost 70 per cent drop in the number of people delayed, which means that more people are being cared for at home or in a homely setting with the care they need. It also means that acute healthcare services are freed up for people that need them.

• More of our health and care teams are working as integrated teams and are being given the authority to make the right decisions for the people they support. For example, our hospital-based teams are fully integrated and work across social work, nursing and allied health professionals to make decisions that support us in getting people out of hospital with the care they need. They rarely need to escalate decisions and work very positively with our third and independent sector providers so that we can do the right support for people.

• We’re live and testing two new self-managing teams, implementing the Buurtzorg principles. Our first two Integrated Neighbourhood Care Aberdeen (INCA) teams are up and running and the teams are made up of District Nurses and Care Assistants. These teams are self-managing, supported by coaches and empowered to deliver 24/7 care and support to their case load.

• We’ve rolled out the principles of the staff engagement tool iMatter across our staff in the HSCP and have had very encouraging feedback with a high response rate and over 73% of those reporting being very engaged in the organisation, informed about decision making and feeling involved. This gives us an excellent baseline to from which to improve in future years.

• Our four localities are at the point of going live – this will see most of our health and care operations being delivered within a locality in the city, focussing increasingly on locality and community need and in planning services with the people we support.

Progress is being made and while this piece focusses on my HSCP, I’m certain that much of this would be reflected across Scotland with new models and improved outcomes being reported in everyone’s annual performance report.

These are challenging times to work in. The financial challenge has never been greater, and our population needs are changing. However, I believe that it’s that which gives us the greatest opportunity for transformation as traditional models and approaches are not going to be sustainable. We can and must change and we have an opportunity to be creatively disruptive as we do so.

There is much still to do, and the mechanics of integration and its governance are complex. However, I absolutely believe that integration gives us the best platform from which to shape health and social care services for the future and to support us in a sustained focus on addressing long standing and unacceptable health inequalities in our communities.
Views from local government on integration

Councillor Peter Johnston, Health and Social Care Spokesperson, COSLA (Confederation of Scottish Local Authorities)

Integration offers Scotland a unique opportunity to achieve innovative and transformational change across the whole health and social care system and I am proud of Local Government’s role in driving the agenda forward. Now into my second term as the COSLA Spokesperson for Health and Social Care, I have witnessed tremendous commitment from councils to make integration a reality and I am pleased that – for the most part – Local Government has been treated as an equal partner with the Scottish Government throughout the process.

Speaking as a councillor, you would expect me to see integration from a ‘Local Government perspective’ and at COSLA we are often asked what Local Government wants from health and social care integration. The simple and honest answer is that we want to deliver a system that works for communities, delivers outcomes for people and continues Scotland’s journey towards public sector reform.

To achieve meaningful change requires a mandate from both Scottish Ministers and locally elected members who provide democratic accountability to the whole of the health and social care system in Scotland. As such, partnership between these two spheres of government in Scotland is fundamental to success and I believe we have done well to foster a sense of joint ownership of the agenda at a national level.

That partnership is crucial to overcoming the challenges that still exist within integration, of which there remain several. Among these challenges is the fact that Integration Authorities must be further empowered and must develop greater autonomy if we are to really achieve what is set out in the law. This requires a degree of concession by both local authorities and NHS Boards and a clear example of where this has not yet been achieved is in relation to unscheduled care budgets.

Another area for attention is the profile of social care, which must be raised and continuously promoted across the integration agenda. A frustration within Local Government is often that social care is seen as an afterthought or, worse, a means to the end of generating savings in acute care or alleviating delayed discharge. Of course, efficiencies through joined-up service provision are an important benefit of integration but we must also look at social care as a valuable service in itself. One which not only provides dignified care to those who need it and enables people who need support to live as full, active citizens who contribute to the economic and social wellbeing of our communities, but also as a valuable industry to the economy which can offer meaningful and rewarding work.

To compound the problem, there continues to be a professional and cultural gap between health and social care and we are working with the Scottish Government and others to bridge that gap by making social care an attractive career choice and looking to develop a shared approach to development and leadership. I hope that our work to deliver the National Workforce Plan will galvanise our efforts to invest in the social care profession.
This must include the third and independent sector providers on whom we rely and, in many cases, whose employees we are referring to when we talk about the workforce.

Finally, I want to emphasise the fact that integration is ultimately a local agenda and emphasise its significance as part of the broader public sector reform landscape. In this sense, health and social care integration can lead the way in demonstrating how cross-agency, locally planned and delivered services can serve our communities best; but it is also important for Integration Authorities and the NHS at large to continue to see itself as a community planning partner above all. That way we maintain the focus on outcomes for communities rather than on organisational structures or on what is, and what is not, a delegated service. To achieve this, an important step change we must continue to encourage is the shift from central commitments centred on inputs to focusing on outcomes and sustainability across the public sector.

Above all, though, we must continue to remind ourselves that integration is a process that requires constant attention and commitment at all levels to succeed. Setting up the structures is a small part of the picture – it is the responsibility of elected members, senior managers and practitioners across the system to continue to make our vision for integrated health and social care a reality.
Integration of health and social care services has been one of the most significant changes in how services are commissioned, delivered and experienced in the last ten years. Whilst the guiding principles included ensuring dignity, individuals’ rights, person centredness and quality and safety in services which are proactively planned, flexible, anticipatory and asset orientated, the overarching principle is actually the pursuit of wellbeing. We know that a “wellbeing perspective facilitates innovation, earlier intervention/prevention and joined up policies and services” and that it can impact positively on peoples’ physical and mental health status, their use of services, their recovery from ill health and has implications for how services are arranged, delivered and funded. To set it as the overarching principle for integration was ambitious and requires a groundswell change in how we think, deliver and measure what we do.

What has this meant for allied health professions (AHPs) and how have we fared in the integration journey? As the third largest staff group in healthcare (and a small but significant group in social care), AHPs are a diverse group of professions who provide diagnostic, therapeutic and reablement/rehabilitation interventions across all sectors. When the Public Bodies legislation was enacted, AHPs were nearing the end of their first national AHP policy, which set out the case for AHPs as ‘agents of change’. Based on this programme’s success, the current AHP Active and Independent Living Programme (AILP) was commissioned by the Minister for Public Health “to make the contribution of AHPs more visible and accelerate the impact and spread of effective practice across Scotland, ensuring an explicit fit with the wider policy landscape.

The programmes’ vision and six ambitions were developed in partnership with over 1,000 stakeholders across Scotland, from people using and providing services, members of the public, informal carers, educators, the ALLIANCE, Scotland Fire and Rescue and the Care Inspectorate. We asked people what keeps them active, healthy and independent, what AHPs should do to support them with this, and what should we prioritise. Our resulting vision, ‘AHPs will work in partnership with the people of Scotland to enable healthy, active and independent lives by supporting personal outcomes for health and wellbeing’, will be delivered through AILP’s six ambitions: awareness, access, partnership, health and wellbeing, workforce and research and innovation.

People told us they wanted help to manage their own health and wellbeing – with access to our services easily and quickly when they needed them. Thus, in line with this and the Health and Social Care Delivery Plan, AILP seeks to look at how AHPs refocus their contribution across integrated services on prevention and early intervention. How do we achieve this given the considerable pressure on unscheduled, unplanned and emergency care? By having personal outcomes at the heart of our vision, AHPs are committed to working with people on what matters to them, on their priorities and to sharing our knowledge and skills in a more collaborative and empowering way.

To address peoples’ personal outcomes and
their wellbeing needs often means that our priorities are not always those of people who use our services. Thus, we require a different way of thinking, of delivering and of measuring the impact of what we do. From a Three Horizons perspective\textsuperscript{50}, AILP aims to create a culture of ‘disruption innovation’ that will help move towards a new model of health and social care – with wellbeing at its core.

Examples of AILP work to date include:

- Partnership working with Scottish Ambulance Services to develop proactive, asset based pathways for people who have fallen but are uninjured, to prevent them being taken to hospital.
- Development of technology solutions for access to self management information and advice to support people with musculoskeletal problems including a GP decision support tool and the Musculoskeletal Advice and Triage Service based within NHS Inform.
- Developing existing vocational rehabilitation services to support people to get into or stay in work – addressing one of the health inequality precursors.
- In partnership with ISD develop a standard AHP activity dataset and national dashboard which will enable integrated services to understand their AHP workforce and service activity.
- Produce analysed nationally costed health and social care data of adults using AHP services matched to where they are on their ageing journey through the national AHP Lifecurve Survey\textsuperscript{51}, which will provide the baseline to drive services towards prevention and early intervention.
- Development of a Request for Assistance model, initially in Children and Young People’s services, which focusses on wellbeing. This work has already seen a decrease in waiting times whilst demand is rising, an increase in self ‘requests’ and children and young people are getting the right level of help and support more quickly.
- Collaboration with NES to develop sustainable learning resources focussed on embedding personal outcomes across services.

What we know already from early Lifecurve Survey results is that most AHPs are intervening too late for people to reach their full potential through rehabilitation/reablement. Over 60% of people who took part in the survey cannot walk 400 yards – this activity is often a ‘tipping point’ for increased difficulty with other everyday activities and increased use of health and/ or social care services. We also know that around 25% of people who see an AHP are fully active and independent in terms of Lifecurve, so what opportunities are there for a different conversation around wellbeing and active and healthy living?

Focussing on wellbeing requires seismic change: a move from being problem solvers to facilitators; from being ‘expert practitioners’ to partners who share knowledge and expertise; from being ‘change agents’ to ‘disruptive innovators’.

Integration principles recognise that people using and providing services are likely to need support, time and skills to work differently to be able to: identify what matters to people; what their outcomes are and; how to work within a relationship based approach to work collaboratively towards that. We need to keep wellbeing at the heart of all we do, and recognise that this is a ‘long haul’ aim.
Social workers – the obvious clue is in the name – work to improve society and the circumstances of people who live within it. Comprising approximately 5% of the 200,000 plus people employed within the Scottish social services workforce, we are a rather small but beautifully formed cog in the proverbial wheel. The integration vehicle would struggle to make any traction without us!

Working in an integrated setting following the 2016 implementation of Integration Authorities wasn’t new; social workers were used to and skilled at working with the NHS, Education and Third Sector colleagues. Information from SASW members suggests it works best if the partnerships are based on mutual respect for each other’s professional roles, and a joint commitment to putting people who use services at the heart of the support or intervention. This requires strong, positive and transparent relationships based on mutual respect.

Social work has protection of title, and with that right come important responsibilities. The BASW code of ethics and the SSSC social services code of practice informs all our work. Social workers uphold rights through practice skills and their statutory authority. We balance the needs of the people we work with and for, with the need to protect individuals and/or the community they are part of frequently within the same situation. This is done against a backdrop of the “having to do more with less” mantra which can be quite restricting but can also allow creative work and solutions, if appropriate autonomy is allowed.

At our MHO (Mental Health Officers) annual conference in October 2017, participants discussed changes in health and social care integration and the double-edged sword of the potential loss of identity as social workers, and an opportunity to show more leadership in the mental health field in integrated management roles. Having a voice within multi-disciplinary teams allows us to be vocal about how resource implications often sit at odds with people’s rights. MHOs have legally enshrined autonomy but might find themselves subject to subtle pressures if the manager of the integrated setting is mandated to prioritise the budget.

Within the complexities of “delayed discharge” scenarios we have heard from social workers who have had trouble in advocating the needs and interests of people and their families, sometimes being instructed to justify placement moves which may not have been in the best interest of a person. This is not acceptable, and we have acted on these matters.

Some social workers who have become part of some integrated teams struggle within a culture, which is not conducive to the best outcomes and fear the profession will be eroded. Receiving an email, which says “you must do” is never the best way to get practitioners to engage in a positive way.

There are however many examples of good practice and well established positive partnerships, and the buzzword within these is “relationships”. It starts with strong leadership and a good management structure, so that staff aren’t being left to “sort it out”. Initiatives such as single access points, e.g. referrals to community care with GP alignment and linking with hospital discharge, are evident across the country.
Health and Social Care Partnerships that are creative, where middle managers have had time to be proactive and have been able to work to stop crisis through reablement, where supervision for social workers and sound workload management is in place and reflective practice opportunities are encouraged – these partnerships are the ones that will stand the test of time.

A great example of this can been seen following the horrendous weather in late February 2018, which saw fantastic examples of social workers working in close partnership to support hospital-to-home care packages to allow beds in hospitals to be freed up.

Best practice in children’s services is when prevention happens instead of “early intervention”. A solid “team around the child” means multi-agency practice so that the child’s plan is focused on best possible outcomes as opposed to only managing potential risk. Person centred care must not become jargon, but the reality for people who need us.

To illustrate what is meant, I refer to a nomination for our annual SASW Social Worker of the Year award of a complex case with a young person and their family. This person had been in hospital critical care for two years. The work was described as resembling a “Clash of the Titans” at the beginning of what was a long journey; two worlds colliding to work through a process to facilitate their safe discharge a year later. The social worker’s skills in bringing the family into the care and decision making process, which ensured that the person’s wishes for themself and their family were given the utmost focus, her sensitivity and support and her communication skills played a huge role within this process.

Despite fears it may not work, the person managed to spend a very happy, settled and enriching year with family and friends. The social worker managed to make this and many more achievements possible by practising social work values of respect and diversity, but most importantly by regularly challenging human rights in terms of what the person wanted for themself and their family. The social worker’s influence in strengthening a multi-disciplinary team in unchartered territory (there had never been a discharge from a critical unit straight to home) was described as “phenomenal”.

This reflects the uniqueness of a proud profession, which should thrive within integrated settings if the culture is there.
Supporting integration with new health and care standards

Rami Okasha, Executive Director of Strategy and Improvement, Care Inspectorate

If integration is the biggest change in health and social care for decades, it is going to take time to embed. For integration to be transformational and improve the experiences of people, then organisations and systems will have to learn to work together in different ways. Across Scotland, that is happening in different ways at a local and national level.

The new health and social care standards, commencing in April 2018, are one of the early pieces of national policy to respond directly to the new integration arrangements. They set out what people should experience from care and support, regardless of setting or profession.

They are radically different to anything that has gone before and are designed to focus quality on the personal experience of care, firmly based on human rights and wellbeing. This world-leading approach is attracting wide and global interest in what is happening in Scotland, because of what the standards looks like and how they were developed.

The first national care standards in Scotland were introduced almost seventeen years ago – but only focused on national policy to respond directly to the new integration arrangements. They set out what people should experience from care and support, regardless of setting or profession.

The new health and social care standards are radically different to anything that has gone before and are designed to focus quality on the personal experience of care, firmly based on human rights and wellbeing. This world-leading approach is attracting wide and global interest in what is happening in Scotland, because of what the standards looks like and how they were developed.

The new standards are relevant across health and social care – services that are integrated, services that are not, early learning and childcare, children’s services, social work, the National Health Service, and community justice. The extensive public involvement of people in developing the standards shows that people want a consistently high quality service regardless of setting. They want to be treated with dignity and respect. They want to experience compassion and kindness from those supporting them. They generally want to be involved in leading their own care and want that care to be responsive to their rights, needs and choices.

Second, the standards are person-led, deliberately pushing the boundary of person-centeredness towards something even more empowering. Virtually all the statements start with “I experience...” or “I am...”. They locate quality firmly through the lens of the person experiencing care. This is empowering for people who may be in unfamiliar or distressing environments and is designed to ensure care professionals reflect on their practice from the perspective of the person.
Third, they are outcome-focused, describing what the consequence of good care should be, not how it should be delivered. Detailed and technical inputs about staff ratios and nutritional intake are replaced by outcome indicators, reflecting that people’s needs, wants and choices are not always the same. For example, a previous descriptor about the minimum square footage of a care home room is replaced by a new descriptor which states “I have enough physical space to meet my needs and wishes”.

Of course, it is very easy to plan and measure to a minimum square footage of a room; it is harder to plan care in a way which is tailored to people’s individual needs. But the new standards are not designed for the convenience of inspectors or professionals. Instead of telling care and support providers what to do, they describe what people should experience as a result of that care and support.

Inputs characteristic of high-quality care will continue to be described in guidance, practice notes and peer-reviewed research. That is how we create a learning and improving system. The assessment of quality, however, becomes whether the experience and outcomes for people are positive. This radical approach means inspectors cannot rely on lists of policies and inputs to check, and practitioners cannot assume their inspections will be positive just by following processes. Practitioners are released to creatively solve problems and innovate to improve. The new standards are designed so practitioners can plan, do, study, act. Inspectors no longer see whether something is done ‘correctly’, but instead ask ‘how successful is this change in improving experiences and outcomes for people?’

This change of thinking is part of a broad shift towards measuring the success of public services by reference to outcomes; that is, the impact they are having of people, rather than the way they are designed and delivered. In health and social care, this releases professionals from having to “do what the regulator says”, and instead fosters innovation. To ensure that people experience the high quality envisaged by the standards, care staff will need to work closely together and with people experiencing care to plan, innovate, change and improve.

The new standards were published in 2017 and are implemented from April 2018. Scrutiny bodies have structured programmes in place to incorporate the standards into inspection and improvement activity from 2018 onwards. Over time, a common set of standards across care will allow people to understand what they should experience, and practitioners to devise innovative and high-quality ways of ensuring they do.

We should not fall into the trap of thinking that because standards have been published, they will immediately become a lived reality for every citizen. If everyone experienced care that was already consistent with the standards, there would be no need for them. Standards which are focused on outcomes are about improvement, not compliance. Their applicability across such a wide range of sectors is an important part of the integration of health and social care.
It is worth noting that this is a slight improvement from earlier years (c. 20%)
We Need To Talk About Integration


27 http://www.eastayrshirecommunityplan.org/Home.aspx


34 http://www.eastayrshirecommunityplan.org/Performance/Locality-Profiles.aspx


41 https://www.uws.ac.uk/study/undergraduate/undergraduate-course-search/integrated-health-social-care/

42 https://www.uws.ac.uk/study/postgraduate/postgraduate-course-search/leading-people-centred-integrated-care/

43 http://www.who.int/servicedeliverysafety/areas/people-centred-care/en/

44 Judith Proctor was Chief Officer of Aberdeen Health and Social Care Partnership at the time of writing this article. She has since taken up post as Chief Officer of Edinburgh Health and Social Care Partnership.

45 http://www.gov.scot/Publications/2015/12/4851


48 http://www.gov.scot/Publications/2017/06/1250


50 http://www.internationalfuturesforum.com/three-horizons

51 http://www.knowledge.scot.nhs.uk/ahpcommunity.aspx

52 https://www.basw.co.uk/resource/?id=501


54 http://www.newcarestandards.scot
About the ALLIANCE

The ALLIANCE is the national third sector intermediary for a range of health and social care organisations.

The ALLIANCE has over 2,200 members including large, national support providers as well as small, local volunteer-led groups and people who are disabled, living with long term conditions or providing unpaid care.

Many NHS Boards are associate members and many health and social care professionals are Professional Associates. Commercial organisations may also become Corporate Associates.

Our vision is for a Scotland where people of all ages who are disabled or living with long term conditions, and unpaid carers, have a strong voice and enjoy their right to live well, as equal and active citizens, free from discrimination, with support and services that put them at the centre.

The ALLIANCE has three core aims; we seek to:

Ensure people are at the centre, that their voices, expertise and rights drive policy and sit at the heart of design, delivery and improvement of support and services.

Support transformational change, towards approaches that work with individual and community assets, helping people to stay well, supporting human rights, self management, co-production and independent living.

Champion and support the third sector as a vital strategic and delivery partner and foster better cross-sector understanding and partnership.

We Need To Talk About Integration
An anthology of contributions by ALLIANCE members and partners
Third and Independent Sectors | Lived Experience | Public Sector and Academia
Published June 2018

The Health and Social Care Alliance Scotland (the ALLIANCE)
Venlaw Building, 349 Bath Street, Glasgow G2 4AA