We need to talk about integration

Health and social care integration: How is it for you?
Views from the public sector

Independent research commissioned by the Health and Social Care Alliance Scotland
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We Need To Talk About Integration

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The 14 individuals who took part in this research had many other pressures on their time. We are grateful to all of them for agreeing to be interviewed and taking the time to talk about their experiences.

Every effort has been made to reflect the views expressed by the interviewees as accurately as possible. Any factual errors made in this report are solely the responsibility of the author and not the interviewees.

The following abbreviations are used throughout this report:

**IJB:** Integration Joint Board. There are 30 IJBs in Scotland and one integration authority (Highland) which operates under a different model, known as the lead agency model. The term Integration Authority is used in this report where both types of models are being referred to.

**HSCP:** Health and Social Care Partnership. There are 31 HSCPs in Scotland, and the geographical areas covered by HSCPs are broadly co-terminus with those of local authorities. There is a single HSCP covering Clackmannanshire and Stirling Council areas; thus the number of HSCPs in Scotland is one less than the number of local authorities. In this report, whenever the term ‘partnership’ is used, it refers to a Health and Social Care Partnership.

**TSI:** Third Sector Interface. The Third Sector Interface network was established in 2011. It is funded by the Scottish Government to ensure that local communities and third sector organisations are adequately supported to participate in community planning processes, and to contribute to the achievement of local and national outcomes. Thus, TSIs provide an important point of contact (or ‘interface’) between the public sector and third sector.
Executive summary

Introduction (Chapter 1)

1. This report presents findings from a small-scale qualitative research study commissioned by the Health and Social Care Alliance Scotland (the ALLIANCE) and carried out in October and November 2018. The study was intended to complement a larger project undertaken by the ALLIANCE in 2018 called ‘We Need To Talk About Integration’ – which was commissioned to mark the second anniversary of the Public Bodies (Joint Working)(Scotland) Act 2014 coming into force. The larger project involved gathering the views of over 30 of the ALLIANCE’s members and partners – people with personal and professional experiences of integration – into an anthology about health and social care integration. The anthology was published in June 2018.1

2. Although the anthology included perspectives from two individuals employed by Health and Social Care Partnerships, there was a feeling within the ALLIANCE that a wider range of views from within the public sector would be welcomed. The aim of this research therefore was to invite a selection of individuals working in the public sector and involved in the planning and delivery of health and social care services, to reflect upon the first two years of the 2014 Act coming into force.

3. Interviews were carried out with 14 individuals – ranging from executive managers to front-line workers. This study used a narrative research methodology. Interviewees were asked to talk about what was working well, what was working less well and what impacts integration was having at a local level. However, the study was not intended as an evaluation; rather the aim was to give people working in the public sector an anonymous space to share their own personal experiences of integration.

General perspectives on health and social care integration (Chapter 2)

4. With few exceptions, interviewees voiced strong support for the aims of integration, and for the ongoing process of service transformation. These views were expressed spontaneously, since the interview did not specifically set out to gather views about the principle of integration.

5. Interviewees generally accepted that, given the demographic changes taking place in Scotland (particularly with respect to an ageing population), a radical rethinking of health and social care services was required, and they saw integration within that context.

6. Almost unanimously, interviewees agreed that service reform was needed (i) to bring about a greater focus on prevention; (ii) to tackle health inequalities; and (iii) to provide seamless, holistic, person-centred care to those who need it – in their own homes. Some interviewees also highlighted the importance of engaging the wider public in this process of transformation – i.e. to begin to change people’s expectations of the health and social care system, and to empower them to take greater responsibility for their own health and wellbeing.

7. Interviewees emphasised that this process will take time. They pointed out that, while the current focus of integration has been all about restructuring health and social care services, integration is not simply about changing structures and reorganisation; rather, the structural changes are intended to support the longer-term aim, which is culture change. And culture change cannot happen overnight – rather, health and social care integration is a ‘change for a generation’.

The challenges of health and social care integration (Chapter 3)

8. Interviewees were asked to discuss some of the challenges they have faced over the past two years in relation to health and social care integration. While interviewees had very different perspectives and experiences, there were nevertheless some common features and recurring themes in their accounts of what health and social care integration looked like for them. Regarding to the challenges, in particular, interviewees generally described one of three
types: (i) organisational, (ii) cultural, and (iii) financial – each of which overlapped to some extent with the others.

9. **Organisational challenges** existed at various levels. At the highest level, there were ongoing challenges (in some HSCP areas) in establishing and agreeing arrangements for decision-making and accountability. Other organisational challenges included the high turnover of IJB members; workforce issues (e.g. staff sickness absence, high levels of staff turnover, empty posts being left unfilled, etc); communication problems (particularly in relation to communicating strategic decisions down through the workforce); and frustrations for line managers (team leaders of integrated teams) of having to deal with separate IT and HR systems in NHS and local authority organisations.

10. Interviewees also discussed **cultural barriers** within the health and social care workforce and within IJB memberships, and they highlighted a need for culture change within the general public – suggesting that there was a need to begin to change the ‘contract’ between the public sector and the general public, and the expectations that people have of health and social care services.

11. Finally, interviewees discussed the implications of **severely constrained finances** – on the recruitment of staff, and on efforts to shift to a more preventative focus in the delivery of services.

12. Interviewees highlighted the importance of leadership (at all levels), locality (keeping services and decision-making local), consistency (of processes and communication), and education (of the health and social care workforce) as key factors in addressing these challenges.

### The successes of health and social care integration (Chapter 4)

13. Interviewees were invited to talk about some of the successes of integration in their areas.

14. Interviewees highlighted three main types of success. These were in terms of: (i) developing a shared vision; (ii) investing in relationships; (iii) establishing a more ‘person-centred’ focus within services. Successful initiatives were often specific to a particular context (or locality), and were not necessarily available across an entire area.

15. Interviewees discussed the time and effort invested at a local level in developing a vision and goals for the future which were shared by all local partners. It was clear that, in some areas, this process had gone more smoothly than in others. However, those who reported successes in this area talked about the benefits of ‘moving forward together’.

16. In addition, the development of a shared vision was often described as a relational process – one which involved investing time and effort in people (key decision-makers, health and social care staff, third sector partners, members of the public, etc). Interviewees at all levels highlighted the importance of this type of work and expressed satisfaction where these efforts bore fruit.

17. Several interviewees had responsibilities for developing and / or implementing new models of care in their local area. Some pointed to successful aspects of these initiatives and cited specific outcomes (e.g. ‘reductions in delayed discharges’, ‘reduced health inequalities among vulnerable mothers accessing antenatal care’, ‘less duplication between hospital-based and community-based practitioners’). Others discussed more general outcomes – i.e. services that were becoming more ‘person-centred’ and ‘locality-based’.

### The third sector in health and social care integration (Chapter 5)

18. Interviewees were asked to comment on the ways that third sector organisations have contributed – and are contributing – to the integration agenda, as well as the challenges and difficulties that have arisen in the process.

19. Different individuals had very different perspectives on the third sector. Some interviewees had little experience of working directly with the third sector at all, while others were most familiar with those third sector organisations that specialised in certain aspects of health and social care – for example, those that provided care-at-home support for older people,
or for people with a specific disability. Some interviewees had a broader perspective and were able to comment on how the third sector was contributing to a range of strategic priorities and initiatives across a HSCP area, while others were working on joint projects with third sector delivery partners.

20. Among those who did have experience of working directly with the third sector – or who had observations to share about the third sector’s contributions to integration at a local level – several issues were raised in relation to: (i) third sector involvement in strategic planning and service delivery; (ii) barriers to closer partnership working with the third sector; (iii) the particular strengths – and weaknesses (in some cases) – of the third sector; and (iv) the disaffection which exists among (some) third sector organisations. In addition, interviewees also recounted specific examples of successful initiatives and activities delivered by the third sector, or in partnership with the third sector.

**What difference is integration making? (Chapter 6)**

21. The 2014 Act requires local services to be based on a set of 12 ‘integration planning and delivery principles’, which are intended to achieve specific health and well-being outcomes. This study invited comments from public sector interviewees about the extent to which two of these principles were operating in their areas. Specifically, interviewees were asked: (i) To what extent do you think people who use services and their carers are involved in the planning and development of services in your local area? And (ii) To what extent are you seeing a shift towards prevention / anticipatory care in local services?

22. The key message from interviewees in relation to both of these questions was that the extent to which these things are happening is variable (some used the word ‘patchy’).

23. Interviewees said that there was variation in the extent to which people who access services, and carers, were involved in the planning of local services. Those in more senior roles emphasised the priority attached at a local level to engaging these two groups – and indeed the wider community – in service planning processes. They also noted that support was given to service user and carer representatives to enable them to participate fully in IJBs. However, those who were responsible for managing integrated care teams, or who were on the front-line of service delivery, did not necessarily have the capacity to get directly involved in this type of exercise, and so were less able to comment on the extent to which this was happening at a local level.

24. Some interviewees – and especially those with a more strategic perspective – commented that there is a much greater focus on prevention and early intervention in the planning of services. Interviewees also discussed the growing emphasis on supporting ‘self-management’ for people with multiple long-term conditions. This is a challenging task which involves changing the dependency that people have on the health and social care system, and instead giving people the skills and confidence they need to look after their own health and well-being more effectively. Interviewees also noted that the third sector and community sector have a key role to play in this type of work. However, it was also common for interviewees to say that the funding simply was not available to allow them to move from a position of ‘firefighting’ to a position of ‘spending to save’.

**Discussion (Chapter 7)**

25. Despite the many challenges and difficulties interviewees faced in relation to the ongoing process of integration, there was nevertheless widespread support expressed about the current direction of travel. However, interviewees also expressed caution about how long the journey was likely to take. Cultural barriers between the NHS and local authorities, in particular, will take time to be overcome, although interviewees also suggested some practical, shorter-term solutions that would make the process easier – including having shared IT and HR systems.

26. There is an expectation from the Scottish Government that integration will lead to (i) closer working relationships across all sectors, (ii) a greater focus on prevention and early intervention in service planning, and (iii) the meaningful involvement of carers and people who use services in the planning and development of services. Interviewees highlighted some of the challenges
associated with these changes; but also gave examples to illustrate that these changes are happening. Given the small-scale nature of this study, it is not possible to comment on how widespread these changes are, but interviewees admitted that, in many cases, success was ‘patchy’.

27. Health and social care services continue to be delivered in Scotland against a backdrop of ongoing austerity. To some extent, austerity is providing an impetus (though not the only impetus) for service transformation; however, it also has the effect of constraining the options for new and innovative service models. These pressures are likely to continue and may be compounded by changes in the workforce brought about by Brexit. For integration to be a success, an ongoing commitment to its aims will be necessary – not only from the public sector, but from the third sector, and from ordinary members of the public – for some time to come.
1. Introduction

1.1 This report presents findings from a small-scale qualitative research study commissioned by the Health and Social Care Alliance Scotland (the ALLIANCE) and carried out in October and November 2018. The study was intended to complement a larger project undertaken by the ALLIANCE in 2018 called ‘We Need To Talk About Integration’ — which was commissioned to mark the second anniversary of the Public Bodies (Joint Working) (Scotland) Act 2014 coming into force. The larger project involved gathering the views of over 30 of the ALLIANCE’s members and partners — people with personal and professional experiences of integration — into an anthology about health and social care integration. The anthology was published in June 2018. Contributors included:

- Thirteen senior managers from third sector organisations (including service user and carers’ groups)
- Two individuals with senior management roles in different Health and Social Care Partnerships
- Five representatives of national public bodies (two from the Scottish Government; one from the independent regulator, Care Inspectorate; one from the national local authority representative body, COSLA; and one from the national health improvement agency, NHS Health Scotland)
- Six people (or organisations representing people) with lived experience of receiving health and social care services, including two unpaid carers
- Representatives from two Royal Colleges and a national social work membership body
- Two representatives from one university (School of Health, Nursing and Midwifery, University of the West of Scotland)

1.2 Although the anthology included perspectives from two individuals employed by Health and Social Care Partnerships, there was a feeling within the ALLIANCE that a wider range of views from within the public sector would be welcomed. This research project involved gathering the views of people in the public sector who are responsible, not only for the planning, but also the delivery of integrated health and social care services at a local level. Given the significant impact of health and social care integration on the public sector, this type of focus was seen to be appropriate and complementary to the work already done.

**Public Bodies (Joint Working) (Scotland) Act 2014**

1.3 The Public Bodies (Joint Working) (Scotland) Act 2014 (hereafter ‘the 2014 Act’) came into force in April 2016. This legislation brings together health and social care into a single, integrated system. Its aim is to ensure that health and social care provision across Scotland is joined up and seamless, especially for people with longer term and/or complex needs, many of whom are older or disabled. New Integration Authorities – in all but one area, Integration Joint Boards (IJBs) – were established, with responsibility for managing £8.5 billion of funding for local services which had previously been managed separately by NHS boards and local authorities. Integration is widely described as the most significant change to the delivery of public services since the creation of the National Health Service in 1948. The 2014 Act requires NHS boards and local authorities to integrate the governance, planning and resourcing of adult social care services, adult primary care and community health services and certain hospital services. Each IJB oversees the work of a Health and Social Care Partnership (HSCP). HSCPs replace Community Health Partnerships, and have the lead responsibility for the strategic planning, commissioning and management of integrated health and social care services at a local level.

1.4 Secondary legislation accompanying the 2014 Act sets out the requirements for membership of IJBs – including equal representation from NHS boards and local authorities. This legislation also requires that IJBs appoint additional ‘stakeholder’ members – i.e. at least one individual (and they have the flexibility to appoint more than one) – from each of the following groups, to represent the interests and views of those groups:4

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2 The anthology is available at: www.alliance-scotland.org.uk/blog/news/we-need-to-talk-about-integration/
3 There are 30 Integration Joint Boards in Scotland and one Integration Authority (Highland) which operates under a different model.
4 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014, section 3(6) and 3(7).
· Staff of NHS boards and local authorities involved in the provision of integrated services
· Third sector bodies carrying out activities related to health or social care
· Service users residing within the area of the local authority
· Persons providing unpaid care in the area of the local authority.

1.6 The requirement to involve the third sector, and service user and carer representatives in IJBs is intended to fulfill the policy intention of the Scottish Government: “to fully and appropriately involve non-statutory providers of health and social care within local partnership arrangements for planning and decision-making.” Such arrangements are consistent with the principles of co-production which underpin the Scottish Government’s vision for mutual and person-centred public services. Co-production recognises that people have ‘assets’ (knowledge, skills, experiences, families, communities, etc.) which can be brought to bear in supporting their health and well-being. Co-production puts the people who receive services at the very heart of those services – involving them in their design, delivery, and assessment.

1.7 The 2014 Act requires that local services are based on a set of integration planning and delivery principles aimed at achieving a set of health and wellbeing outcomes.

Aim of the research and overview of methods

1.8 The aim of this research was to invite a selection of individuals involved in the planning and delivery of health and social care services and working in the public sector to reflect upon the first two years of the 2014 Act coming into force.

1.9 Interviews were carried out with 14 individuals – ranging from executive managers to front-line workers. This study used a narrative research methodology. Interviewees were asked to comment on what was working well, what was working less well and what impacts integration was having at a local level. However, this study was not intended as an evaluation, and no attempt has been made to assess or comment upon the progress being made towards integration in different areas of Scotland against specific outcomes. Instead, the focus was on giving people space to share their own personal experiences of integration. Further details about the interviewees, the ways in which they were recruited to participate, and the interview topic guide are provided in Annex 1 of this report.

About this report

1.10 This report presents the findings of a small qualitative research project which explored (i) how integration is being experienced by a range of individuals working in the public sector; and (ii) the effects (at a local level) that are beginning to be seen.

1.11 The report contains seven chapters as follows:

- Chapters 2-6 present the main findings of the project, looking in turn at general views on integration (Chapter 2); the challenges (Chapter 3) and successes (Chapter 4) of integration to-date; experiences of involving, and working with, the third sector in integrated health and social care teams (Chapter 5); and the effects of integration (Chapter 6). The specific effects of integration explored in this study were the extent to which: (i) service users and carers were involved in the planning of services at a local level, and (ii) there was a shift in focus at a local level towards prevention and anticipatory care.
- Chapter 7 discusses and reflects upon the key findings of the study.
- Annex 1 provides information about the methods used to conduct the study.

1.12 It is important to bear in mind that this study was based on a small non-representative sample of participants. Therefore, the findings should not be taken as typical of the experiences of public sector staff across Scotland more widely. Indeed, some interviewees specifically commented that health and social care integration was likely to look very different in different parts of the country. At the same time, there were many common features in the experiences and perspectives gathered through this study, and so it is likely that these findings will resonate with the experiences of many other people working in the public sector in Scotland.

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5 Public Bodies (Joint Working)(Scotland) Act Policy Memorandum, see paragraphs 20-21. www.parliament.scot/S4_Bills/Public%20Bodies%20(Joint%20Working)%20(Scotland)%20Bill/b32s4-introd-pm.pdf
7 These principles are set out in section 4 of the Act: www.legislation.gov.uk/asp/2014/9/section/4
2. General perspectives on health and social care integration

2.1 This section discusses two general topics frequently raised by interviewees: The first was in relation to people’s views about the principle of integrated health and social care services – and about the direction local areas were moving in. The second was in relation to the timescales for integration.

Views on the principle of integration – the need for a paradigm shift

2.2 One of the most striking findings of this research was that, with few exceptions, interviewees voiced strong support for the aims of integration, and for the current ongoing process of service transformation. These views were expressed spontaneously, since the interview did not specifically set out to gather views about the principle of integration. Interviewees talked about a health care system that is ‘in crisis’, and ‘crumbling on its feet’, and they noted that the current model of health care – established in 1948 – was simply not designed to cope with the nature and enormous scale of the current demands on it. Others commented that social care has historically been significantly under-funded as compared with the NHS. Some interviewees often pointed to two facts:

- That Scotland’s population is ageing, and people are living longer with increasingly complex, long-term conditions.
- That those living in the most deprived communities are more likely than those living in less deprived communities to suffer from poor health while, at the same time, having least access to health resources.

2.3 Interviewees generally accepted that a radical rethinking of health and social care was required, and they saw integration within that context. They argued that simply trying to squeeze greater efficiency (higher productivity at less cost) out of the traditional model of health and social care, or making greater use of technology (for example, through tele-care systems, etc.), would not be enough, and would ultimately fail to meet the massive growing demand on the health and social care systems – unless a more radical ‘paradigm shift’ also took place.9

2.4 Almost unanimously, interviewees agreed that service reform was needed, to bring about a greater focus on prevention; to tackle inequalities; and to provide seamless, holistic, person-centred care to those who need it – in their own homes. Some interviewees also highlighted the importance of engaging the wider public in this process of transformation – i.e. to begin to change people’s expectations of the health and social care system, and empower them to take greater responsibility for their own health and wellbeing.

2.5 Some interviewees also pointed to examples from elsewhere in the world, where integrated health and social care services are planned and delivered within small geographic localities and are achieving positive outcomes. The Danish healthcare system10 and the Nuka model in Alaska (USA) were both referred to as models that Scotland could potentially learn from.11

2.6 In addition, it was noted that the need for change in Scotland has, in fact, been recognised for many years – but that previous attempts to make it happen without the force of legislation were not successful.

2.7 Thus, despite the many challenges and difficulties interviewees saw in the current integration process, nearly all of them were convinced that the changes now being made were (i) vitally necessary, and (ii) would ultimately be beneficial. One executive

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9 One interviewee referred to the book ‘Humanising Healthcare: Patterns of Hope for a System under Strain’, by Margaret Hannah, which clearly sets out case for transforming healthcare services, and offers a strategy for developing a more sustainable culture of healthcare based on examples from around the world.
10 Danish Ministry of Health (2017) Healthcare in Denmark – an overview. This document (in English) provides an overview of the way in which health and social care services are funded, delivered and governed in Denmark. See www.sum.dk/~/media/Filer%20-%20Publikationer_i_pdf/2016/Healthcare-in-dk-16-dec/Healthcare-english-Y16-dec.ashx
11 Information about the Nuka system of care is available here: www.kingsfund.org.uk/publications/population-health-systems/nuka-system-care-alaska
manager expressed this sentiment as follows:

‘I honestly think that needs must. It won’t necessarily be a painless process, but with all of the risks – Brexit, the retirement bump that we’re about to hit, the growing needs of an ageing population, etc. – all of that is very real to people right now. And I think we’ll be seeing growing waiting lists... I think we might be forced to see that services might just not be able to continue to function. We can’t recruit, we can’t retain, people retire and leave, things have become unsustainable. I think change will be forced upon us... The change agenda really is live, everybody knows everything needs to change, I suspect it just needed that push. So I am reasonably confident that change is going to happen, and it’s going to change for the better, and that kind of thing will actually force the issue of – guess what, statutory services can’t do everything. We need to take seriously a third sector role, and look at what people can do to help themselves, peer support, etc., etc. So I’m reasonably confident that there will be positives that will come out of this process.’

Executive manager

2.8 Interviewees were also encouraged by the steps that had already been taken at a local level to begin the process. Significant challenges and difficulties were acknowledged; but, at the same time, interviewees said they felt encouraged by the positive energy they saw around them of people working towards a new, shared vision. One senior manager commented:

‘There is a growing climate of innovation, of looking to do things differently, and not a desire to hold on to the status quo. I think there will be pockets of that, but I feel around me, in the kind of circles that I’m moving in, I feel that sense of people wanting to do better and knowing that to do better means continually reappraising ‘is this service appropriate? How could we make it more accessible? How could we make it more effective? How can we get in front of the game by coming in at an earlier stage?’

Senior manager

A dissenting voice

2.9 While the overriding impression given among the interviewees who took part in this study was one of massive change at a local level, there was also, in general, a sense of optimism about the future. There was, however, one quite different perspective to that set out above. One individual argued that:

‘The integration process has been brought about by a need to cost-cut, and that need to cost-cut is, I think, fuelled by politics. I think that the reduction in services to people in need is horrendous, and – what are we, the seventh wealthiest country in the world? – and we are stepping backwards in time. We are becoming a nation of greed and selfishness, and I hate being part of this.’

Front-line worker

2.10 While this perspective was not typical of the individuals interviewed in this study, the findings presented in Chapter 3 (regarding the challenges of integration) show that this may not be an uncommon perspective among front-line health and social care staff.

Timescales for integration

2.11 The second issue that was raised frequently among respondents, and particularly those in senior or executive management roles, was in relation to the timescales for integration. Again, this was an issue that interviewees raised spontaneously, rather than one which they were prompted to discuss. Interviewees often said that, although the current focus of integration has been all about restructuring health and social care services, integration is not simply about changing structures and reorganisation; rather, the structural changes are intended to support the longer-term aim, which is culture change. And culture change will not happen overnight:

‘The size and the scale of the challenge has become apparent over the three years that I’ve been working here, and none of that was visible beforehand... We have now got something of a measure of how big the challenge is, and it’s not going to be quick. It’s going to take time... We’re on a journey, and I think it’s going to be a change for a generation. It’s not going to be something that will be delivered within a couple of years after the starting of the partnerships. However, I think all of the building blocks are there.’

Executive manager

2.12 This same individual later commented on the current pace of change, and the extent to which major changes in services were taking place before all the necessary skills, systems and processes were in place to support them.
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2.13 Another interviewee echoed this point, and also suggested that there may be unrealistic expectations, not only about the time required to establish the partnerships – but also to achieve the longer-term goal of culture change:

‘There was never any realistic expectation communicated to communities, to the public sector, you know, regarding how long it would take to get these partnerships up and running – and to overcome the fact that you were bringing at least two different cultures together, local authority and health – and that all the governance would need to be put in place.’ Executive manager

2.14 And a third interviewee also made a very practical point about the timescales for integration – highlighting the time required for practitioner training and development:

‘There’s certainly something about...shifting the responsibility from doctors to nurses, pharmacists and mental health staff and others as part of a multi-disciplinary approach, and that will take time. So therefore, an expectation that change will come this year or next year is slightly inappropriate given that people have to go through a year’s training to become a prescribing nurse. People have to go through development to become those independent practitioners.’ Senior manager

2.15 The various challenges which have been touched upon here are explored further in the following chapter.
3. The challenges

The integration of health and social care is an ambitious undertaking. In the first two years since the 2014 Act came into force, Health and Social Care Partnerships (HSCPs) and Integration Authorities have faced many difficulties and challenges – many of which are still ongoing. However, interviewees noted that there have also been many successes. The individuals who took part in this study were asked to talk about some of the things that had worked well, and less well, in relation to integration over the past two years – i.e. the challenges and successes of integration. This chapter discusses the challenges that individuals identified. Chapter 4 will look at some of the successes.

3.1 The integration of health and social care is an ambitious undertaking. In the first two years since the 2014 Act came into force, Health and Social Care Partnerships (HSCPs) and Integration Authorities have faced many difficulties and challenges – many of which are still ongoing. However, interviewees noted that there have also been many successes. The individuals who took part in this study were asked to talk about some of the things that had worked well, and less well, in relation to integration over the past two years – i.e. the challenges and successes of integration. This chapter discusses the challenges that individuals identified. Chapter 4 will look at some of the successes.

3.2 Given their very different perspectives, interviewees highlighted a wide range of issues under the general heading of ‘challenges’. Some spoke at a personal level about difficulties they had faced in their job (for example, as a team leader responsible for managing an integrated care team). Others discussed matters that were less ‘personal’, but which related to more strategic issues based on their experiences and observations as an executive or senior manager.

3.3 While interviewees had different perspectives and experiences, there were nevertheless some common features and recurring themes in their accounts of what health and social care integration looked like for them. In relation to the challenges, in particular, interviewees generally described one of three types: (i) organisational / structural, (ii) cultural, or (iii) financial. Furthermore, there was not necessarily a clear separation between these kinds of challenges; rather there was considerable overlap between them.

3.4 Before discussing the challenges highlighted by interviewees in further detail, it is worth reiterating that this study was not intended to evaluate the progress being made towards integration in different areas of Scotland. Rather, the intention was simply to describe what integration looks like – from the perspective of those in the thick of it – at this time.

3.5 The three main types of challenge identified by interviewees are discussed below – together with any suggestions that interviewees had about how these challenges could be overcome.

3.6 Interviewees talked about organisational challenges at various levels.

Organisational challenges

Authority and decision-making between HSCPs and NHS boards (and to a lesser extent, between HSCPs and local authorities)

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Organisational challenges

Authority and decision-making between HSCPs and NHS boards (and to a lesser extent, between HSCPs and local authorities)

3.7 At the highest level, within certain HSCP areas, interviewees reported ongoing challenges in establishing and agreeing arrangements for decision-making and accountability. Even where new committee structures had been established and strategic plans had been agreed, there continued to be tensions, most often between HSCPs and NHS boards, about (i) which aspects of health and social care should be under the direction / authority of the partnership(s) and which were the responsibility of the board; (ii) how resources should be allocated; and (iii) which corporate entity was responsible for managing certain resources. In some areas, it was reported that attempts made to resolve these serious fundamental questions had resulted in conflict and damaged relationships. One interviewee commented that this issue was the number-one challenge for integration in her area:

‘I think the challenge around integration is related to decision making and authority, and who has the right to make decisions. So in the absence of a clarity around decision making and authority comes a bit of confusion and apathy which delays change.’ Senior manager

3.8 Such issues appeared to be particularly problematic in areas where there were two or more HSCPs within a single NHS board area. Indeed, interviewees commented (either from personal experience, or from observation) that where an HSCP was co-terminus with its NHS board, the process of establishing clear lines of authority between the partnership and the NHS board appeared to have gone more smoothly and worked reasonably well. However, (mainly) in areas where there were multiple HSCPs associated with a single NHS board, interviewees highlighted a number of specific issues related to:

- Set-aside budgets: this refers to the money for functions that are provided by large hospitals, but which are delegated to IJBs, such as unplanned care.12

12 This issue was not discussed in detail in any of the interviews. However, it was highlighted as an area of concern by several interviewees. Thus, it is worth providing further information about the nature of the problem. A recent Audit Scotland report, Health and social care integration: Update on progress, (November 2018) discussed the problem of set-aside budgets as follows:

‘Instead of paying this money to the IJBs along with payment for other delegated services, it is identified as a budget which should be directed by the IJB. The complexities around accurately preparing set-aside budgets has presented challenges to fulfilling this element of the Act. To date, the set-aside aspect of the Act is not being implemented. In line with Scottish Government guidance, NHS boards continue to manage the set-aside as part of their own resources.

In 2017/18, £809.3 million was included within IJBs’ budgets for set-aside (where they were able to include a set-aside figure). This is 9.0 per cent of IJBs’ income and is therefore a significant element of the health and social care budget that is not being directed by the IJBs. If IJBs are to use resources more strategically to prioritise prevention and care in a community setting, this issue needs to be resolved.’

• **Implementation and performance management of programmes and contracts:** An example was given of the current GMS contract for GPs – where the Chief Executive of an NHS Board is accountable for the contract, and doctors have contracts with the NHS board, but the partnerships are responsible for the planning and resourcing of adult primary care services.

• **Supervision and direction of staff:** Some interviewees (particularly those based in hospitals or ‘central’ services within NHS boards) commented that prior to integration, their work (or the work of staff they manage) was closely aligned with the priorities of the NHS board. However, since integration, they feel they are being ‘pulled in different directions’ by the NHS board and the partnerships. This was particularly problematic where there were multiple partnerships associated with a single NHS board, because each of the partnerships may also have different strategic priorities. These interviewees said that they were not always clear about who had the authority to set their priorities, and they (or their staff) found it confusing that they were employed by one organisation but answerable to one or more others.

3.9 In relation to the challenges of decision-making, one interviewee also raised the issue of trying to provide integrated services to children, when one of the key partners is education. However, (at least in this particular area), the education authority is not represented on the IJB – even though education provides a substantial portion of the funding for children’s services at a local level, and both the IJB and the education authority share a focus on early intervention and prevention.

**High turnover of IJB board members**

3.10 Another organisational challenge at a high level related to the turnover of IJB board members. One executive manager reported that in the three years of operation of the local IJB (including one shadow year), there had been 19 changes of board members – ‘and that’s just the voting members, never mind all the others.’ Part of the reason for this is that roughly half of the voting members of an IJB are elected councillors, and in this period, there had been a council election which led to some board members not being re-elected. This interviewee highlighted

the benefits of new people coming in and bringing fresh perspectives – but also acknowledged the difficulties relating to the loss of ‘organisational memory’.

3.11 It was not clear from the information gathered from other interviewees the extent to which this level of turnover was typical of other IJBs in Scotland. However, several executive and senior managers reported having invested a great deal of time and effort in establishing a formal induction and development programme for new board members; developing a shared vision, aims and strategy; and prioritising relationships within the board. (These initiatives are discussed further below in relation to successes.)

**Workforce issues**

3.12 Interviewees highlighted a range of challenges in relation to the health and social care workforce. As already noted above, there were difficulties for some NHS-based staff who (since integration) now have a remit which requires them to work across multiple HSCPs – and who now feel they are being pulled in different directions.

3.13 One senior manager suggested that some staff are simply weary of change and did not always fully understand what the benefits of those changes were:

> "It’s easy to say this but it’s absolutely true; change is all about people, and if people buy into the change, and if people are clear there’s going to be a benefit to the people that they serve and it’s going to make their job easier, and if that’s what’s going to make them happier at work, then yeah, they’ll go ahead and do it. But I don’t think we have that set of circumstances yet.’ Senior manager"

3.14 There were also reports of staff sickness absence, high levels of staff turnover (including among team leaders), and posts being left unfilled because of a lack of finance, or because the HSCP had not yet taken a decision about the allocation of resources in certain areas. One front-line worker also pointed out that the private sector, which provides important care-at-home services to older people and other vulnerable adults in his locality, was also under severe strain at present because of high staff turnover. While these comments referred specifically to private sector care providers, they undoubtedly also relate to third sector homecare providers.

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13 In some areas, it has been agreed that children’s services, or children’s health and care services, are delegated to the IJB.
‘The carers aren’t paid particularly well, you know, it’s a wage. It’s above the national minimum wage, usually, but their terms and conditions because they work for private companies aren’t anything like they used to have [when home care services were provided by the local council]…. Now people jump ship all the time, and if they can get an extra 10p an hour working for another company, they’ll jump ship, because that makes quite a difference to them. If they get a better rate per mile for travelling, to keep their cars on the road, if they even are paid for their travelling time, then they will move from one care provider to another.’

Front-line worker

3.15  This same individual had also noticed that Eastern European care home staff had begun to return home to their countries of origin because of the uncertainty of their future after Brexit, and that care home staff from other non-European countries were returning home because their visas were not being renewed.

3.16  One executive manager saw the process of integration as enormously positive, but acknowledged that for people at the front line, it had been an extremely unsettling time.

‘So I can see that over the past two or three years, that for folks working out in the partnership itself, that a lot of the work that’s been going on is about who is accountable to who, who has actually got the power here, who is the lead, where does accountability lie… and there was a lot of change, and a lot of uncertainty for people working within the system about what would happen to them.’

Executive manager

3.17  One senior manager painted a more detailed picture of how integration has appeared to front-line staff in another area:

‘So, yes, it’s absolutely correct that people should work together and join up resources and reduce any duplication and ensure that people get a seamless service, and all of those good things – co-location, if possible – all the things that are good practice – and, when creating the conditions for integration, it would be useful to follow these kinds of principles. But what we’ve ended up with is that people have had to reapply for jobs, there have been reorganisations, people have got jobs that other people expected them not to. Really, it’s a bit of a mess. From an organisational structures point of view… I’m not sure what the vision actually was.’

Senior manager
Information technology (IT) systems

3.19 Finally, in relation to the wide range of organisational challenges highlighted by interviewees, one theme that recurred on a remarkably frequent basis concerned the difficulties – especially for team leaders and front-line workers – of having to deal with separate IT and HR systems. The range of points made by interviewees illustrated the more general point – touched upon in Chapter 2 – that the pace of change – in terms of restructuring health and social care services – was exceeding the pace of change in the systems that are needed to support the new structures.

‘I guess every staff member has their concerns, you know, where they sit, what they do, how they do it, and what their terms and conditions are, so I don’t think there’s been enough national work done to help systems talk to each other. I think one of the biggest challenges is getting a system that we can all use, and clearly we’ve got hundreds of different systems, IT systems that don’t talk to each other, and that’s frustrating as heck. I have to say that’s probably the biggest barrier to integration in my opinion. Communication is number one, and the second is making sure everybody’s happy in their role. So, if you want to make integration work for the staff – I’m not saying necessarily for the people, although the people at the other end will get the benefit of that – then the two biggest things haven’t been really touched yet in my opinion.’ Front-line worker

‘I guess if I were to look at it at a very practical operational level, the result of me managing NHS staff as well as local authority staff is that I’ve had a double of my systems. For example, absence management, the HR processes, the annual leave, the annual review, I’ve got an absolute duplication…well I’ve got two completely separate systems for what happens in relation to the NHS staff and what happens for the local authority staff, and at the moment I’m not seeing any reduction of that. So there have been frustrations in terms of different systems in place, different cultures in place and different aspects of even sharing data – all of the underlying systems and processes – why we do things and how we do it, and then the recording of it. That has caused a challenge and I think it still does.’ Senior manager

Cultural barriers

3.20 The second main type of challenge that interviewees highlighted related to the different cultures in NHS and local authority services.

3.21 As previously noted, interviewees often expressed the view that health and social care integration was not primarily about structural change – i.e. simply arranging for different professional groups to work together, out of the same office, under the same manager. Rather restructuring is a means to support the real aim of integration which is, ultimately, culture change – a ‘paradigm shift’ as one interviewee described it. There were several aspects to this. Different interviewees suggested that culture change was needed within the health and social care workforce; some suggested that education and professional training has a key role to play in this.
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However, culture change was not only needed within the health and social care workforce; rather, it was needed within IJB memberships, and within the wider public. These different aspects are discussed below.

**Need for culture change within the health and social care workforce**

3.22 To some extent, the organisational challenges just described were seen as a reflection of the underlying cultural differences between NHS organisations and local authorities. However, cultural challenges were described as relating to something deeper than where people sat in the office and who their manager was. Instead, they concerned the fundamentally different views that healthcare providers and social workers have of the world. These views of the world are based on distinctive roles, different regulatory regimes and governance systems, and separate professional training. One interviewee commented:

‘I think in terms of culture, we are continuing with the ‘clinical model’ and the ‘social model’ as opposed to there being one fully integrated model underpinning what we’re trying to achieve. … There are some deep underlying principles that are still different in terms of the medical model and the social model, that need to be ironed out.’ **Senior manager**

3.23 Different interviewees often gave specific examples of the ways in which the different cultures within NHS and local authority services acted as barriers for people to come together and deliver care in a more integrated way.

‘So for example, we had to build a facility that had a wall up the middle of it because the environmental regulations for health and care institutions are different, we obviously have different regulatory frameworks in which we operate, and we are trying to bring some of those things together, and the corporate support to make this stuff happen around finance and HR, and planning etc., it’s not been as easy as perhaps it could have been.’ **Executive manager**

3.24 At a more operational level, team leaders discussed the way in which cultural barriers made it difficult to persuade some staff to see the benefits of new ways of working. Some reported that they had faced resistance from staff, and one individual reported that staff in her integrated team had (at least initially) refused to recognise her authority as team leader:

‘I think there’s been challenges in people accepting my role within health. So certain health members of staff have been quite resistant to my role, resistant to my management role because they see themselves as being health staff and see me as being a social work member of staff. And there have been language barriers and procedural barriers, but also just an unwillingness to accept my authority as well.’ **Team leader**

3.25 Another team leader noted that, in the multi-agency team she managed, there had been good progress among the staff in one specialism in relation to taking on new tasks; however, other team members were reluctant to take on jobs traditionally seen as ‘belonging’ to another sector of the workforce.

3.26 Some interviewees also pointed to specific areas of (mainly) healthcare where it had been particularly difficult to develop a shared understanding of how services should be working. Acute hospital services were identified as one of those areas by several (though certainly not all) interviewees. It was not entirely clear whether the difficulties with acute services reported by some interviewees related to the issue of multiple IJBs associated with a single NHS Board and tensions regarding the control of funding, already discussed in this chapter; or whether the issue was related more broadly to the distinctive ‘culture’ of acute hospital services. Indeed, it may be both.

‘I think we’ve got a lot of work still to do with our acute hospital service colleagues. I don’t think the move towards integration has made the same impact there, and we’re still having to find ways of working together with the acute service to make the kind of sea change we need to make towards more community-based services. … I don’t think we’ve got the momentum yet, for creating the right kind of relationships between the integration joint boards and the acute services that respects the knowledge and understanding of the acute hospitals system. You know, I don’t know how the day to day processes operate and what’s working well and what’s not working well; they can tell me, but I don’t know it with any degree of expertise. So we need their expertise. But likewise they need to learn to accommodate the new vision about how health and social care services should be more focussed on prevention, early intervention community-based services. And I think that’s a problem for them because they only see what comes into the hospital. They don’t see the opportunities back in the community to do things differently.’ **Senior manager**
Cultural barriers within IJBs

3.27 Some interviewees pointed out that the different cultures of NHS and local government organisations – and the differing roles of non-executive NHS board members and elected councillors – can also be played out within the membership of an IJB. One executive manager discussed the process of bringing these two groups together to form the voting membership of the IJB.

‘So the NHS non-execs are very used to working on a board, and they’re used to that structure. The local authority councillors were very different. They have a more adversarial approach, and they work quite differently with their local authority officers and expect a different relationship with their officers. The NHS non-execs, their behaviours and performance were based very much on the values of the NHS. So when we first started meeting it was really, really difficult, as you can imagine, with these two different cultures. And the councillors… I mean, it was such a big ask for the councillors to be able to start to get their heads round what the NHS actually does, because it’s a huge service… So they had to be able to understand all that, and at the same time be an active integration joint board member. But they kept reverting back to what they know, which was the role of an elected member and their accountability to the people who elected them. And they would often get involved in operational issues, which is not the role of a board member. That’s the role of the executives who deliver the services.’

Executive manager

Changing public expectations

3.28 Finally, some interviewees made the point that it was not just within NHS and local authorities where culture change was needed. Rather, a new ‘contract’ was also needed between the public sector and the general public. Several interviewees talked about the need to engage with members of the general public to begin to change expectations of the health service – to encourage (and support) people to take greater responsibility for managing their own health and wellbeing.

‘So we’re trying very hard to move our model for community services to one that helps people to help themselves rather than doing things to people, and in that sense, we’re beginning to see a change in the staff – the staff themselves need to move away from some of the models they were trained in, and be courageous to do different things – and then the expectations of the public can sometimes just be for somebody to come along and fix their problem, and they may or may not be engaged in helping themselves or may not have the knowledge to help themselves.’

Executive manager

Financial challenges

3.30 The third and final type of challenge that nearly all interviewees raised was in relation to finance. While some interviewees saw the current economic climate as the main driver for change, others saw it merely as one of several factors which has helped people focus with greater urgency on making the changes that everyone has known for years must be made. Either way, interviewees (and particularly senior and executive managers) expressed concerns about budgets, and the potential impacts on services of having to continue to find millions of pounds worth of savings year to year, or to address substantial projected deficits for the current year. One senior manager discussed the very challenging situation in his own area:

‘Last night was an emergency IJB meeting where we were basically trying to work out what we were going to do to about the £X million deficit, and therefore it’ll be things like not allowing people to go to care homes, or not having care packages for people which means they’ll end up being a delayed discharge…. This area has a very old population, it’s a dependency ratio which is on a scale of what Japan is now, and what the rest of Scotland will be in about 25 years. We have lots of 90-year-olds, 100-year-olds, and increasing dependency because of the outward migration of economically active people. So, in a sense, finance is the issue, I’m afraid, and in particular, the historic underfunding of social care.’

Senior manager

3.31 Some interviews remarked that the ‘Transformation Fund’ provided by the Scottish Government in the first few years of integration had been helpful in allowing HSCPs to develop new models of care. However, this fund was now exhausted, and some interviewees acknowledged that large-scale changes in services are only beginning to be made. Furthermore, the expected transfer of funding from the acute sector out into the community sector is still not happening in the way that was expected:

This issue will be discussed further in

Chapter 5 (in relation to third sector involvement in integration) and in Chapter 6 (in relation to the difference that integration is making).

14 A precise figure was given by the interviewee, but it has been removed to protect their identity.
‘I think the reality is sinking in. In the first couple of years when the big transformation funds were provided, that actually enabled a lot of really good change work to happen. Things were able to be set up, you know, we set up a community hospital at home, virtual wards…because the money was there to invest, to double run, and it didn’t require releasing the assets from acute sector out to community services. So the partnerships had relatively large sums of money – seven figures – to spend to make things different, to really make a change. And I think that all lent real power to them to be able to make things happen, do things differently, test things out. But of course that money was finite, and it was fixed term, and I suppose what it was meant to do was to get things started, but it’s probably going less well now that money is all spent. And we…I think like most other areas, I know that overall there’s been a reduction in the amount of funding going into acute, and an increase in the proportion going out into community and primary care. But it’s really not happened at the pace that has been required.’

Executive manager

Lack of finance is having significant implications for the delivery of key services

3.32 Various interviewees discussed the impact of constrained finances on specific services, including acute hospital services, primary care, community rehabilitation, care homes, care-at-home services and a wide range of third sector services. Interviewees also talked about posts within teams that had been left unfilled, and the frustration of not being able to roll out a new and innovative, evidence-based model of care because the funding simply was not available to allow it to happen.

3.33 One interviewee discussed the difficulties that she had had in recruiting a new member of staff, and in securing long-term funding for a new programme she had developed, which had been shown to be highly effective:

‘So everyone has their own perspective and their difficulties, we’re working in an era of financial scrutiny. We’re also working in an area where what we’re doing is new, and people want to see that…if we’re going to fund this, is there going to be a benefit from it. And so we’ve had a massive amount of work where we’ve had to deliver evidence about what we’ve been doing, to show that it is effective. But we have now delivered that evidence consistently, and the frustration has been that…we get another six months, and then we get another 6 months, and we might get a year or one partnership gives us a little bit and somebody else…, we’re still waiting for an answer for. But all in all, that contributes to being unable to recruit.’

Senior manager

3.34 One front-line worker explained that, to avoid delayed discharges, the area he worked in (like many other areas of Scotland) had made arrangements with care home providers for the temporary use of a ‘step-down’ bed – a kind of intermediary stage between hospital and home – which allows time for a care-at-home service to be arranged. While this arrangement solved one problem, it sometimes created others.
Finding solutions to overcome the challenges

3.36 While interviewees reported a wide range of significant challenges arising in the efforts to bring about health and social care integration, at the same time, it was common for this group to have a clear sense of what some of the solutions were too – as well as what the solutions were NOT. These are summarised very briefly in the paragraphs below.

3.37 Interviewees saw the main solutions in terms of (i) leadership, (ii) locality, (iii) consistency and (iv) workforce education and training.

Leadership

3.38 Interviewees often highlighted the importance of leadership – and by this, they did not necessarily mean leadership at a strategic level by chief officers and senior management, though that was acknowledged to be important too. Rather, interviewees saw the need for leaders at every level, in every type of service – not only in the public sector (health and social work), but also in the third sector and indeed within the community sector. The need for consistent political leadership by elected representatives was also emphasised, and some interviewees discussed cases where politicians, who should be supporting the strategic decisions taken by a HSCP on the basis of evidence and considerable discussion and consultation – instead reversed the decision in light of public protest.

3.39 Among senior managers and team managers, there was a view that even those who were not in formal management roles could provide leadership – by opening their eyes to new ways of working, and finding creative ways to work in a more integrated fashion with colleagues in other kinds of services.

3.40 In terms of strategic leadership within IJBs, executive managers noted that a development programme had been established for the chief officer network and for IJB Chairs. One executive manager saw this as important for developing new and different kinds of leaders:

‘The intention has been that we’re a different type of public service leader, that rather than getting into issues of power and control, we’re very much more around about enablement and team-working – working alongside long-established institutions where perhaps the rules of engagement are somewhat different.’

Executive manager

Locality

3.41 One of the most challenging issues identified by interviewees (as discussed above) related to situations where there were multiple HSCPs associated with a single NHS board. One interviewee talked about this problem in his area at some length but expressed optimism that the boards and the partnerships would eventually reach agreement about where decision-making authority lay and how the acute sector could
begin to devolve more of its responsibilities to the community sector. This individual was concerned that one of the potential solutions to the difficulties arising from this arrangement might be to ‘regionalise’ IJBs / HSCPs – i.e. to expand the geographical coverage of these organisations so that they were co-terminus with the NHS board. This individual was strongly of the view that this would be a mistake.

‘I think we have made great strides locally because we’re relatively small.... I don’t think there is an argument for saying we should have co-terminus IJBs and health boards, because in areas like Greater Glasgow and Edinburgh, you lose all the opportunities you have to establish good links with practitioners – GPs, voluntary organisations, and with the public more generally. The bigger the scale the more difficult that becomes. So I think it’s important not to see the solution as creating much larger integration joint boards.... There was a report that came out at the time of integration called ‘All Hands on Deck’, I’ve forgotten who wrote it, but it was seen as a fairly key document by the policy makers at the Scottish Government at the time.15 And it placed a very strong emphasis on the importance of locality. So we need to find a way of doing both, you know, managing the acute hospital conundrum without losing the benefits of becoming more locally responsive.’

Senior manager

‘There used to be far greater barriers between social care and nursing, and there were a lot of practice barriers, practical barriers, but also cultural barriers that separated the two groups of staff. But we’ve consistently just reinforced the message that they’re one team, that they’re working together.... We’ve smoothed out things like recording processes with systems we use, the forms we use, so that everybody’s using the same processes to work with, and that is lessening the feeling that there’s two separate camps within the one team.... We’ve integrated every layer of the process [of providing care to an individual], from referral to completion, and we’re constantly reinforcing the message that we’re integrated, we’re integrated, we’re integrated, so that there aren’t opportunities for people to create divisions or separateness.’

Team leader

3.43 One issue which was raised spontaneously by some interviewees concerned the education of people working in the health and social care sectors. The view was expressed that the reorganisation of services provided one of the key building blocks for health and social care staff to work together in a more integrated way. However, to achieve long-term culture change, the training and education of healthcare workers, social workers and social care workers had to be radically transformed too.

Consistency

3.42 As noted above, some interviewees highlighted resistance to change among front-line staff – including staff they were responsible for managing. In some cases, matters improved over time as staff began to accept the role of a new manager or became comfortable working with new processes. Managers also talked about the practical steps they had taken to develop new assessment and review forms which could be used by everyone in the team (even if other aspects of their work continued to be recorded separately within NHS and social work IT systems). These kinds of activities were seen not only to improve efficiency within the team, but they also helped to break down the cultural and ‘practice’ barriers between team members from different professions. One team leader talked about her experience, and the consistent messages she gave to her team:

15 The report referred to here was a think-piece produced by Frank Strang, then Deputy Director of the Scottish Government’s Directorate of Health and Social Care Integration, and published by the Scottish Government in July 2013. It is available at: http://www.jitscotland.org.uk/wp-content/uploads/2014/10/All-Hands-on-Deck-2013.pdf
3.44 One interviewee commented that, as far as he could tell, undergraduate curricula for health and social care staff had not yet caught up with the concept of integration. This individual suggested that newly qualified doctors, nurses and social workers were still leaving their courses with a misapprehension of what their future careers will entail, and this was likely to have severe consequences for the long-term viability of these professions and for specialist services:

‘I have experience of talking with various groups and being involved with professional development, etc. I’ve spoken to Social Work Scotland, I’ve spoken to the AHPs [Allied Health Professions], I’ve spoken to nurses and I’ve spoken to medics, and not any of them – none of them – in their undergraduate curricula are having any instruction on what’s coming...what they’re going to encounter when they get out.... They’re still being taught the traditional things, and therefore, I think, unless that changes, we’re going to have difficulty, because people will come out with an expectation of their working lives that might be quite different from what society requires of them in the future. And that might be one of the reasons that people don’t stay, or choose to go, and you have gaps in specialist services.’

Executive manager

3.45 This view was echoed by another interviewee who suggested there needed to be a re-think about the way in which health and social care workers are trained:

‘I almost wonder about whether there needs to be a development of a third way in terms of – you have staff that are both medically and socially trained. There are other models where there’s more flexibility about what is health and what is a social service, with individuals that are able to provide both. So I think there’s something in how staff are being developed and trained in the early stages that could almost support and mirror [what we’re trying to achieve with integration]? And I know there are some experiments in some areas where health workers have tasks involving both health interventions and social care. It’s a more wrap-around type service. So I guess that would be an area of interest where we, as with all change, acknowledge that the different cultures exist, and that we need to invest a little bit more in adopting a new culture, and then the old cultures can just ebb away.’

Senior manager

3.46 A range of other interviewees commented that ‘staff need to move away from some of the models they have been trained in’, that they need to be ‘courageous to do different things’ and that they need to ‘open their eyes to new ways of working’. This is undoubtedly a complex and challenging issue, given the different legislative frameworks that the health and social care workforce operate in. However, interviewees emphasised the importance of transforming professional training to better support these changes.

3.47 The next chapter will discuss the successes of integration identified by the interviewees. As will be seen, some of these issues (particularly in relation to leadership, locality and consistency of processes and communication) were recurring themes in these accounts.
4. The successes

4.1 The previous chapter described the wide range of challenges interviewees had faced in the first two years of integration – and were continuing to face. This chapter will look at some of the successes of integration to date.

4.2 Although the successes highlighted were often very specific to a particular context, they also shared a number of features. Moreover, these often mirrored the challenges, in that, at least in some cases, successes related to challenges that had been overcome. Not surprisingly, therefore, certain issues identified as challenges by one interviewee were discussed as successes by others in different parts of Scotland.

4.3 It was also clear that success was not necessarily uniform across any particular HSCP / IJB area. Interviewees often stated explicitly that successful initiatives in one part of their area were not necessarily replicated across the entire area – thus, success was ‘patchy’ and ‘not universal’.

4.4 Interviewees highlighted three main types of success. These were in terms of: (i) developing a shared vision; (ii) investing in relationships; (iii) establishing a more ‘person-centred’ focus within services. Each of these will be discussed below.

4.5 Three other successes often identified by interviewees related to (i) new ways of engaging with, and delivering services in partnership with third sector organisations (these will be discussed in Chapter 5); (ii) efforts to engage with members of the public regarding the planning of services; and (iii) a shift towards prevention and a greater emphasis on supporting people to better manage their own health and well-being (these latter two will be discussed in Chapter 6).

Developing a shared vision for the future

4.6 Interviewees discussed the time and effort invested at a local level in developing a vision and goals for the future which were shared by all local partners. It was clear that, in some areas, this process had gone more smoothly than in others. Those who reported successes in this area talked about the benefits of ‘moving forward together’ and contrasted this situation with various alternative scenarios.

‘I think the concept of it [integration], it’s the way that we should be going, we should be moving forward, and I think, when we can truly look at it to say – ‘right what should we be doing, that’s best for this client group or this group of the population, and who is best placed to deliver that?’ – when that can be done without people fighting over… ‘well that’s our budget, that’s your budget’ – that has to be a step in the right direction. So in the areas where that’s happening, that would definitely be one of the successes.’ Senior manager

4.7 It should be noted that this interviewee went on to say that not everyone in her area had necessarily signed up to a new shared vision for integrated services, and that, in fact, some disagreements were not merely in relation to control of resources. Rather, some individuals were also sceptical about whether proposals for changes to services were always sufficiently evidence-based.

4.8 One of the main changes that interviewees remarked upon was the increasing prominence of ‘prevention’ and ‘reducing equalities’ as guiding concepts for the strategic planning of services. Some suggested that those in strategic planning roles had embraced a more anticipatory, person-centred agenda, and that there was a new energy and excitement at a local level about the opportunities that integration presented. The two quotes below illustrate the substantial level of buy-in in some areas for this change in focus – and the willingness to challenge old ways of thinking – which was, in itself, seen as a kind of success:

‘The question is how do we create a system that supports frontline services and staff that work within them to support people with long term conditions to live well with those conditions, despite those conditions? We’ve got lots of evidence here locally that a lot of people have bought into that agenda – that person-centred agenda, you know, the meeting of equals involving a clinician and patient, making sure that people have got the information they need, the whole Realistic Medicine agenda, etc., etc. So a lot of people have bought into the idea that we need to move away from a very hierarchical top-down approach of doing things to people, to working with people… But of course, what you hear from people working in clinical services is that there are lots of organisational and structural obstacles in the way of that – in the way that systems are set up, how pathways work, how long you get for an appointment – there’s all of these barriers to working in that way. So the question for me was, if we want things to grow from the grass roots and to be organic, if you like, and for people on the front lines to have ownership of the agenda, what can we do from a top-down strategic point of view – what do we need to put in place – to allow that to happen? And what I’ve definitely seen with the partnerships is quite a radical and quick move towards talking about prevention and seeing the need to do things proactively, and the need to change services to be proactive, rather than just reactive. That felt like a real change.’ Executive manager
Investing in relationships

4.9 The development of a shared vision was often described as a relational process – one which involved investing time and effort in people (key decision-makers, health and social care staff, third sector partners, members of the public, etc.). Interviewees at all levels highlighted the importance of this type of work, and expressed satisfaction where these efforts bore fruit. Given the different roles that interviewees had, the nature of these efforts varied. For example,

- One executive manager discussed the steps she had taken to ensure that all IJB board members, whatever their backgrounds, felt valued and confident to be able to contribute to board discussions.
- One senior manager talked about the ‘groundwork’ that had been carried out and the engagement with local primary care services to get support for rolling a new model of delivering integrated care to people with long-term conditions across multiple partnership areas.
- Another senior manager discussed the efforts that had been made to strengthen links – not only between health and social care, but also with housing, transport, leisure and the police – to create ‘a new kind of environment, internally and externally, which promotes the health and well-being of our population’.
- Team leaders highlighted the efforts they had taken to ensure that everyone in their team had a clear understanding of their own role and responsibilities, and the roles and responsibilities of everyone else in the team.
- One front-line worker talked about a joint meeting that now takes place in his local health centre every week involving GPs, physiotherapists, mental health officers, pharmacists, social workers, and community nurses – where each member of the team can bring any concerns they may have about any patient / client whom they feel may benefit from additional support in the community.

4.10 It was common for interviewees to say that one of the successful outcomes of these efforts was that there was less ‘silo working’:

‘I think we’ve got stronger relationships within the partnership. I think we are absolutely developing much more of a community feel to how we are delivering our services, that we’re actually engaging and participating in community discussions round about what our own area needs ... and being able to have some of those conversations that will lead us to make decisions that are hopefully in the best interests of our own community. And I think that’s been really positive for us ... I think there’s a better understanding of some of the services that are being delivered for our populations and what that means and how we can work together and remove some of the silo working that previously we might have seen. I think there have been some real positives round about the relationships – and the working relationships – that we’ve got, moving forward.’ Senior manager

4.11 The individual quoted above went on to say that one of the other outcomes of investing in relationships was that strategic decision-making in her area felt much more ‘inclusive’ than it had before the advent of integration; she and her colleagues now feel that they have ‘a stronger voice’ at the table:

‘The strategic conversations are much more inclusive. So, at a partnership level, I think the representation round the table is much more inclusive, and the debate and the conversations about who else needs to be involved – there’s been a shift in culture and ethos in relation to recognising the validity of a whole range of services coming together. I think we [i.e. a particular group of NHS staff] have a stronger voice within the partnership than we had previously within just within our health service. And we’ve been able to come around the table more to really look at collaborative practice.’ Senior manager

4.12 At least two of the interviewees were from HSCPs covering relatively small geographical areas. These individuals suggested that one of the advantages of being part of a small community is that everyone knows each other and is willing to work together to overcome cultural barriers for the sake of the person they are caring for. One of these individuals noted that ‘you have easier access to people – you can call a meeting that brings everyone round the table’. In other words, stronger
relationships can be fostered between services.

4.13 There was also a view that any successes which could be attributed to integration were down to people, doing the right thing for the client or patient. One senior manager made this point as follows:

‘I think challenges are always overcome by people, because people, in the end, if they are honest, they’ll do what’s in the best interest of the client, what’s in the best interest of patients.’ Senior manager

Successes in service delivery

4.14 Several interviewees had responsibilities for developing and/or implementing new models of care in their local area. Some pointed to successful aspects of these initiatives – even where, in some cases, the process of rolling out the initiative was still at a relatively early stage.

4.15 Some interviewees discussed changes that had been made to the processes for accessing and moving through services (i.e. redesigned care pathways), innovations in primary care services, investments in re-enablement services, and the establishment of a multi-disciplinary assessment unit in a local hospital.

4.16 While some discussed the successes of these changes in very specific terms (e.g. ‘reductions in delayed discharges’, ‘reduced health inequalities among vulnerable mothers accessing antenatal care’, ‘less duplication between hospital-based and community-based practitioners’), others pointed to more general outcomes – i.e. that services (and the strategic planning of services across a locality) were becoming more ‘person-centred’ and ‘locality-based’. Again, these changes were seen as (initial, early) successes of integration.

‘The other dynamic that I’ve seen much stronger this last two or three years, is a move towards being person-centred, rather than simply addressing the illness and addressing the symptoms. I’m seeing people in all walks of life adopting that approach. It’s not easy when you’re busy and your primary job is... perhaps as a district nurse to address the pressure sore or whatever, but I think there is a desire to shift towards being more person-centred.... Despite things like the introduction of the outcomes approach probably about 10 years ago now, it’s only in fairly recent times that I’ve seen that [person-centred approach] becoming the mantra for all of us, whether it’s GPs or voluntary sector staff or whatever. There’s a danger of me painting too glossy a picture here, I think it’s still a journey, but I hear ‘person-centred’ being referred to much more routinely and, I think, with more conviction.’ Senior manager

‘I think that health and social care is moving in the right direction. It’s provided a really positive opportunity for our team to work differently and to work more holistically, and to be...instead of based in hospitals, to be based much more in church halls and to be working with areas that are deprived. And lots of our service users say they wouldn’t have come to this if it had been based in a hospital. So it’s the fact that we’re going out and doing it somewhere else that’s been a success, and lots of our people [patients / clients] say they were just sitting in their house doing nothing.’ Senior manager

4.17 Finally, one interviewee described a successful local initiative developed for people affected by multi-morbidity (i.e. more than one long-term condition). The new programme provides tailored support from a team of nurses and physiotherapists, working with staff in a local leisure centre. The programme not only allows staff from the rehabilitation service to refer patients to the leisure centre, but also allows staff in the leisure centre to refer people into (or back to) the rehab service – rather than requiring people to have to go through the GP in every case. The interviewee commented that the leisure centre staff participating in this initiative had been invited to attend all the training days offered to the rehab team – and this interviewee reported that ‘they came to every bit of training that we did’. In addition, a further spin-off from this work involved the manager of the rehabilitation team working with a local further education institution to develop a new course for personal trainers:

‘So another offspring of this has been that – we don’t think that further education institutions create fitness instructors who are actually fit to work in this industry! So we have been working with [further education institution] to start a new course that trains a person, not just to be a PT [personal trainer] to the healthy, but to teach them to work with people who have got health conditions, and broaden their students’ thoughts about outcomes and careers at the end of their courses. So that’s another piece of work that’s come from this as well.’ Team leader

4.18 The next chapter will focus on the public sector’s involvement with the third sector, and will include a description of additional service-level initiatives identified as successful by interviewees – specifically, those that involve partnership working between the third sector and public sector.
5. The third sector in health and social care integration

5.1 This chapter discusses public sector perspectives on, and experiences of, the third sector’s involvement in integration. The focus here is primarily on interviewees’ accounts of the ways that third sector organisations have contributed – and are contributing – positively and imaginatively to the integration agenda, as well as the challenges and difficulties that have arisen in the process.

5.2 The third sector comprises a highly diverse range of charities, social enterprises and voluntary groups, which play a vital role in supporting individuals and communities at a local level. The Scottish Council for Voluntary Organisations (SCVO) reports that there are an estimated 45,000 voluntary organisations in Scotland, employing around 138,000 people. These organisations (i) provide essential and specialised services, (ii) help to support people’s health and well-being, and (iii) contribute to community development and economic growth. Two-thirds of third sector organisations in Scotland are involved in social care-related activities. They include both large organisations with offices across Scotland (and indeed elsewhere in the UK), and small community groups led entirely by volunteers. Half of third sector organisations in Scotland are registered charities.

5.3 Thus, in this study, when interviewees were asked, ‘How well are things working with the third sector?’, not surprisingly, the responses were also diverse. Different individuals had very different perspectives on the third sector. Some interviewees had little experience of working directly with the third sector at all, while others were most familiar with those third sector organisations that specialised in certain aspects of health and social care – for example, those that provided support for older people, or for people with a specific disability. Some interviewees had a broader perspective and were able to comment on how the third sector was contributing to a range of strategic priorities and initiatives across a HSCP area, while others were working on projects that were being delivered jointly by the public sector and third sector.

5.4 Among those who did have experience of working directly with the third sector – or who had observations to share about the third sector’s contributions to integration at a local level – several issues were raised in relation to:

- Third sector involvement in strategic planning and service delivery
- Barriers to closer partnership working with the third sector
- The particular strengths – and weaknesses (in some cases) – of the third sector
- The disaffection among (some) third sector organisations
- Examples of successful partnership working with the third sector.

5.5 Each of these is discussed below.

Third sector involvement in strategic planning and service delivery

5.6 It was common for interviewees to report that the third sector is represented – generally via a local Third Sector Interface (TSI) organisation – on IJBs, HSCPs and on transformation committees and programme implementation steering groups. Interviewees appreciated the perspectives offered by their third sector partners in these contexts. This sentiment was expressed clearly by one interviewee:

‘They [staff from a local third sector organisation] are so passionate and have got such a perspective and such a lot to offer that, to have them involved in the room to help shape the thinking is a fantastic thing.’

Executive manager

5.7 As noted above, however, different interviewees had different levels of information, and different experiences, of working directly with the third sector. One executive manager had a very informed perspective on the types of third sector organisations that operated in his locality:

‘We have something like 3,000 voluntary organisations in this area, of which 900 are charities. Hundreds of people are involved through the various third sector bodies who contribute to the delivery of services and so... there are things like men’s sheds and memory groups and that type of thing, where people are taken to something that they enjoy that would also help them remain sharp for as long as possible, or to remain physically active for as long as possible.’ Executive manager

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17 Ibid.
However, one interviewee made the point that, in her area, public sector staff have struggled to develop closer working relationships with the third sector while so much effort has gone into reorganising public sector services. ‘I guess we probably don’t work with them [the third sector] as closely as we should. I think there’s been so much focus on statutory services and trying to reorganise and bring them into place so that they [i.e. statutory services] work better, the third sector hasn’t had as much focus – especially as time and money have got tighter. I think there’s been certain cuts made that have affected the third sector in the first instance. So, I don’t think it’s working particularly well. I think there’s a lot of good work going on – participatory budgeting for smaller groups – but I don’t think there’s enough links for us to refer into… I don’t think there’s enough third sector work for us to refer into, and have a good knowledge of it.’ Team leader

Barriers to closer partnership working with the third sector

The quote above highlights an example of the way in which a lack of capacity in the public sector can prove to be a barrier to developing – or even exploring – closer working relationships with the third sector. Other interviewees identified barriers in relation to funding processes and cultural issues too.

Funding processes

Some interviewees highlighted serious challenges associated with having the third sector more involved at a strategic planning level. There were two main issues identified. First, unlike the public sector, the funding given to third sector organisations cannot ordinarily pay for staff to attend meetings outwith the specific requirement of the project objectives; and second, public sector procurement rules regarding ‘conflict of interest’ do not allow an organisation to tender for a contract if that organisation has had a key role in developing the specification for that contract. It is because of these two issues that the third sector representative on many IJBs or HSPCs or other strategic planning committees is often the chief executive or other senior staff member of the local Third Sector Interface (TSI) – which, according to one interviewee, is not always an entirely satisfactory solution:

‘Public sector organisations are of course just funded, and you just do stuff because you’ve got the funds. Whereas the third sector are paid to deliver specific things. On a short-term basis, even though they would love to be really involved around the strategic agenda and the planning agenda, they’re not being paid to come to those meetings, and coming to those meetings doesn’t necessarily help them to demonstrate what it is that they are being paid to deliver. And then there’s the conflict of interest issue in terms of, if they’re at meetings where services are being talked about that are going to be commissioned, if it’s something that they might want to put a tender in for, then there’s an immediate conflict of interest for them. I’m not sure we’ve figured out all of the ins and outs around that. And the default position seems to be that we just have the representatives of the local third sector interface organisation round the table. But with the best will in the world, there’s no way that our TSIs, great as they are, wonderful as they are, and as engaging and as passionate as the folk that work for them are, there’s no way that they can speak on behalf of every single third sector organisation in their patch.’ Executive manager

Cultural barriers

Occasionally, interviewees also talked about the cultural barriers that prevented more integrated working with third sector organisations. Some reported that there had been concerns raised or resistance from (some) staff in the public sector where closer working arrangements with the third sector had been proposed. These concerns often related to issues of trust, different governance arrangements, different internal decision-making processes, and disquiet about unqualified staff being asked to perform tasks that have traditionally been carried out by qualified staff. The following three quotes highlight some of these points:

‘I think there are lots of positives and there’s lots of opportunities [to working with the third sector]...I think one of the challenges...that was highlighted with a lot of the work that I’ve been involved with, with the third sector is the differences in the governance and process arrangements within health, and comparing that to within the third sector. So, if you were going forward with a joint project that’s maybe been initiated through a third sector organisation being granted funding for a project, they’ve obviously got to get off the mark really quickly because they’ve got to meet their targets and
provide the evidence that they’ve used the money in the right way to deliver what they set out to deliver. And if we’re doing that in an integrated way, then the systems within health and social care are much slower. So that’s been a challenge that we’ve had to overcome, because I think sometimes within health and social care we get too bogged down in a lot of the bureaucracy that slows things down, and if we’re working with the third sector we’ve got to be able to respond more quickly. … It’s like…you know, people coming together and at the end of a discussion there’s still no decision made. We’ve got to really get quicker at making those decisions because we can’t put them off for another two months.’

Senior manager

‘There is a strong component of working with volunteers and the third sector’ [in a new programme of work], and that had been relatively unknown to the team. And that was quite a barrier – to convince people that this is something that would be a success, and not only that, it caused fear amongst particularly our unregistered staff, that their roles were going to be taken over.’

Senior manager

‘You know, the health board have always done things in a certain way. But Health and Social Care Partnerships have come in and said, ‘oh we have a commissioning plan, and we don’t want nurses anymore, we prefer to have the third sector deliver that element of the service’. That’s really difficult. It might make sense for the third sector or voluntary organisations to provide that, but it would have to be additional rather than a replacement, and there is room for that, absolutely, in relation to shifting the balance of care, whereby, you know, the demographic trends suggest we’re going to have more older people, and there’s a potential for more complexity in people’s health or social circumstances. There will be a need for a more expert approach, so therefore the professional staff who are qualified to do that should do that.’

Senior manager

**Strengths (and weaknesses) of the third sector**

5.12 Interviewees highlighted the good work being done by many third sector organisations in their areas. The third sector was reported to be particularly active in: (i) facilitating the involvement of communities in decision making processes, (ii) supporting self-management among people with complex and long-term conditions, and (iii) delivering activities and initiatives to support positive health and wellbeing in local communities.

5.13 Interviewees also emphasised their appreciation for the person-centred approach taken by third sector organisations, and (as suggested above), they recognised that the third sector can often get things done far more quickly than the public sector can. One interviewee, who had a lead role in his locality for developing services to support people in self-managing multiple long-term conditions shared his views about the strengths of the third sector:

‘…[T]his idea that health, well-being, living well despite or with long term conditions and multi-morbidity – it isn’t just the job of the health system. In fact, it isn’t just within the scope of the health system. We need to recognise and value the community’s place-based approaches, asset-based approaches, and build capacity within communities – all of that. We need to do all of that, and value it. And our third sector colleagues, we automatically look in their direction and think, ‘well actually that’s a large part of what they’re about.’

Executive manager

5.14 It was unusual for any of the interviewees in this sample to be critical of the third sector. However, one executive manager expressed the view that the TSI in their area seemed not really to understand what the IJB needed from them.

‘Honestly, I think the problem is that the third sector interface don’t seem to understand what it is the IJBs want… For example, if we are looking at a transformation business case for, I don’t know, say, it’s got something to do with older people who have got hearing problems, and who are also isolated and lonely – and we’re planning to change a service. So what we’re looking for when we’re looking at these transformation businesses cases in committees, is for the third sector interface to say, ‘Actually looking at that, you know, the hard of hearing group could help with that bit and really take that on, and visit people in their homes and help to make sure that their hearing aids are repaired. And that could also act as a way of cutting down their isolation and loneliness.’ That’s what we’re looking for from the third sector, because we don’t know all the different groups that are out there. We don’t know where they are, we don’t know what they do, we haven’t a clue. So the third sector [interface] need to be actively involved and really proactive in knowing and being really well informed about all their different community groups and their different third sector groups. They need to be able to represent all these groups when we’re looking at transformation business cases in particular.’

Executive manager
5.15 This may indicate that the TSI representative on the IJB is not familiar with the range of third sector organisations in the area, or it may simply be an indication that the IJB needs to be clearer with the TSI about what they want and need from them. Either way, this experience seemed to be quite different from that of another interviewee who reported that their local TSI had developed a public-facing website that listed all of the groups and activities available throughout the area to support every stage of life.

“So, if you’ve got somebody in front of you asking, ‘where can I get support for breast-feeding’ or ‘where can I join a walking group’, or ‘are there any activity groups for my autistic son’, you can just use that as a search tool. It’s a bit like ALISS, but a bit more bespoke and local, and...I think what we need is a local thing. So that’s an example, and I’m sure if we’d have done that it would have taken forever and a day, and we’d have had to go through all the usual guff, procurement stuff and all that, whereas they’ve just done it quickly!” Senior manager

5.16 Another relatively uncommon view expressed among interviewees was that there can be a lack of choice for commissioners when putting projects out to tender to the third sector in rural and remote areas.

Disaffection within the third sector

5.17 As discussed above, occasionally the interviewees in this study expressed disaffection with one or more specific third sector organisation in their locality. However, these relatively few critical remarks were made in the context of more positive experiences reported by other interviewees. At the same time, there were also reports of disaffection within the third sector for the way in which decisions (particularly in relation to funding) were being taken by IJBs, and the lack of input that third sector organisations have to these decisions.

5.18 One interviewee commented that this situation – a feeling of being inadequately represented in relation to decision-making – was causing a great deal of anger among some third sector organisations in some areas (though not her own, as far as she was aware). She had observed representatives of certain third sector organisations express anger and frustration that decisions about contracts and/or the termination of funding were being made without the third sector being able to influence those decisions, since the third sector representative on an IJB is, by law, not a ‘voting member’ of the board.

5.19 This interviewee had commissioned research in her own area to find ways of ensuring that the third sector representative on the IJB, and other non-voting members, felt valued and confident to contribute to IJB discussions.

Examples of successful initiatives led by the third sector

5.20 Interviewees often highlighted a wide range of specific projects where the third sector was playing a significant role in supporting health and social care integration at a local level. It did this by working in partnership with the public sector to deliver – or even by driving – new models of service provision. Such activities generally involved supporting self-management, or they had an early intervention or prevention focus.

5.21 One interviewee from an area that was in the process of rolling out a ‘House of Care’ model in their primary care services, reported that the third sector was represented on the programme board, and played an integral role in providing support to people in the community to better self-manage their long-term conditions. Other interviewees discussed their relationship with (i) third sector housing providers, (ii) third sector organisations involved in providing care-at-home services under a Self-directed Support arrangement to people with learning disabilities or autism, and (iii) those who provided support to people moving on from addiction.

5.22 One interviewee recounted that, in his area, third sector organisations were involved in helping people in care homes become more active in various creative ways.

“There are also particular programmes for care homes, where they compete in a sort of an Olympic style competition across all the care homes in [Local authority name removed] and you get everybody taking part in physical activity. It is called ‘Go for Gold’, and it’s done really well.” Executive manager

5.23 This chapter has discussed the role that the third sector has in many areas in relation to early intervention and prevention, supporting self-management and wellbeing among people with long term conditions, and facilitating community engagement in strategic planning processes. Chapter 6 will discuss interviewees’ experiences of these specific issues in further detail.
6. What difference is integration making?

6.1 Chapter 1 (paragraph 1.7) noted that the 2014 Act requires local services to be based on a set of 12 ‘integration planning and delivery principles’, which are intended to achieve specific health and well-being outcomes. This study invited comments from public sector interviewees about the extent to which two of these principles were operating in their areas. These were that:

- Services are planned and led locally in a way which involves engagement with the local community – including people who use services, the carers of people who use services, and those who are involved in the delivery of health or social care.
- There should be a focus within services on anticipating needs and preventing them from arising.

6.2 Specifically, interviewees were asked: (i) To what extent do you think people who use services and their carers are involved in the planning and development of services in your local area? And (ii) To what extent are you seeing a shift towards prevention / anticipatory care in local services?

6.3 The responses to both these questions are discussed below. However, the key message from interviewees in relation to both these questions was that the extent to which these things are happening is variable (some used the word ‘patchy’).

Involvement of service users and carers in the planning of services

6.4 The 2014 Act requires all IJBs to have representation from people who access health and social services and from carers. Among those interviewees who were in a position to comment on this aspect of service user and carer involvement, it appeared that such representation is in place. One interviewee discussed the efforts that had been taken at a local level to providing training and ongoing support to these representatives on the IJB. This same interviewee also described the steps taken to ensure that these – and other ‘advisory’ (i.e. ‘non-voting’) members of the IJB – felt valued and confident to take part in IJB committee discussions.

6.5 There was variation in the extent to which interviewees said that service users and carers were involved in the planning of services that they were responsible for. This variation may relate to the role that an interviewee had. Those in more senior roles emphasised the priority at a local level of engaging service users and carers – and indeed the wider community – in service planning processes. They also gave examples of HSCPs organising regular community meetings and engaging communities in participatory budgeting – sometimes with the assistance of Community Link Practitioners.

6.6 One interviewee discussed the structures that had been put in place to support members of the public, service users and carers to contribute to strategic planning decisions, and programme and project development in his area:

‘Below the level of the IJB, we have a series of programmes, and we’re working on getting public involvement in those. We have local action partnerships within each of our localities, and it is largely members of the public who form that. And then, on the IJB we have two primary members and two alternate members for service users and carers as representatives, and they have a forum of people that sit behind them – both the carers and service users – and that’s run by our third sector interface organisation. Now the other thing is that in every project that we undertake we are duty bound to ensure that we involve the service users in that.’ Executive manager

6.7 However, those who were responsible for managing integrated care teams, or who were on the front-line of service delivery, did not necessarily have the capacity to get directly involved in this type of exercise. Interviewees also recognised that involving service users and carers in the development of services takes time and requires capacity. As one interviewee said, ‘it is often the one thing that drops below the radar because of other pressures’. Nevertheless, across all the interviewees, specific examples were given where service users had been involved in project or programme steering groups, and / or where feedback was sought from service users and carers on a regular basis and services were changed as a result.

6.8 One team leader said that she had commissioned research in her area among the families of service users, and that the research was carried out by people who had formerly accessed similar services in another locality.

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19 Participatory budgeting is a way for ordinary people to become involved in deciding how public money is spent in their area.
6.9 There were also examples given where former clients of a particular service got involved in delivering certain aspects of the service as a volunteer peer supporter (i.e. helping current clients of the service to better manage their condition). The quote below explains what she learned about people’s motivations for volunteering as a peer support worker:

‘All of our volunteers have been through our service, and I’ve just done a questionnaire with them, asking them about their experience. So, out of, say, 31 volunteers, 23 have sent back their questionnaire. And the one factor that every single person has put down as a reason for them volunteering – the one that was 100% in their answers – was to give something back. So the value that they’ve received from the service contributed to them wanting to then become a volunteer, and to give it back to others.’

Senior manager

6.10 Some interviewees – and especially those with a more strategic perspective – commented that there is a much greater focus on prevention and early intervention in the planning of services. One interviewee discussed the changes that he was seeing in his local area:

“I feel that sense of people wanting to do better and knowing that to do better means continually reappraising ‘is this service appropriate? How could we make it more accessible? How could we make it more effective? How can we get in front of the game by coming in at an earlier stage?’ Things like addressing isolation, you know, if you go back 10 years, that would not have been seen as a priority for social care and health care, it would be seen as something that was important for the population, but not a responsibility of public bodies who were to focus at the hard, professional end of health and social care problems. I think now we see isolation as something that is well worth addressing to prevent longer term physical and mental health problems. It’s self-evident now, but I see a big change towards embracing that kind of thinking.’

Senior manager

6.11 One interviewee expressed her enthusiasm for the early intervention work taking place among children and young people (and their families and communities) in her area:

“My working world relates to children and young people, and we have made significant shifts in terms of prevention and early intervention. So we have some fantastic and exciting collaborative projects that are moving forward, about meeting needs at the very first opportunity.... There’s a recognition across the system that we need to think differently, and we need to be trying to reduce needs as early as possible... So we’ve been working within one of our communities where, we looked at the data and we recognised there were significant needs, and that the outcomes for children were not as good as we would want them to be. And we have then worked together across the board – so we’ve brought together health visitors, community practitioners, early years workers, educational psychologists, speech and language therapists, child minders, parents – absolutely everyone – to look at, what are the things that we could potentially do? How do we upscale our community? How do we try and create an environment for our children that gives them the best opportunity to develop those skills early on in their life, so that we’re setting them up to have some really positive outcomes later on.’

Senior manager

Anticipatory care and prevention

6.12 Interviewees also discussed the importance of ‘self-management’ for people with multiple long-term conditions – and the challenging task of changing the dependency that people have on the health and social care system, and instead giving people the skills and confidence they need to look after their own health and well-being more effectively. As discussed in Chapter 5, interviewees also noted that the third sector and community sector have a key role to play in this type of work.

6.13 Interviewees acknowledged the importance (indeed, the ‘absolute necessity’) of shifting resources to support more preventative approaches, and they also emphasised that this was a strategic priority at a local level. Nevertheless, it was also remarkably common for interviewees to say that the funding simply was not available to allow them to move from a position of ‘firefighting’ to a position of ‘spending to save’.

‘I think if the budget allows, it’s a fantastic thing, and most people are on board with that [the concept of prevention and early intervention]. But no, I don’t think there’s enough funding for it at the moment, we’re dealing with critical situations on a firefighting basis rather than being preventative. That’s the level of demand and staffing that we have, if I’m honest.’

Front-line worker

‘But the money still sits in the health board under the acute sector, and I guess what we’re seeing is... the reality is that the partnerships are all overspending on the services that they have to provide. It’s really challenging for them...It’s not that people aren’t sympathetic to it, it’s just that the money isn’t there. The money to spend to save isn’t there, and actually, services are being cut. In the efforts to maintain frontline reactive services, we’re seeing that, despite all of that early enthusiasm, that some of our preventive services and preventive budgets are being cut.’

Executive manager
7. Discussion

7.1 The purpose of this small qualitative research project was to gather the perspectives and experiences of health and social care integration from a selected group of people in the public sector. The study provided an opportunity for a range of individuals in this group to reflect on the previous two years since the Public Bodies (Joint Working) (Scotland) Act 2014 came into force. It gave them an anonymous space to talk about what integration looks like from where they stand. The research was intended to complement work undertaken by the ALLIANCE in 2018, which has been published in an anthology, *We Need To Talk About Integration*.

7.2 This study involved 14 individuals from the public sector in different parts of Scotland. The interviewees worked in a wide range of roles – and included front-line workers, team leaders, senior managers and executive managers. They were asked to talk about (i) what the challenges of integration have been; (ii) what’s working well (or the successes so far); (iii) the third sector’s involvement in integration in their area; (iv) the extent to which people who access services, and carers, are involved in the planning and development of services; and (v) the extent to which prevention and anticipatory care feature in the strategic planning of services at a local level.

7.3 Given the qualitative nature of this research, the findings presented here cannot be seen as representative of the experiences of people working in the public sector in Scotland. Nor can the views and experiences of any one individual be generalised to others in similar roles in other parts of Scotland. However, the study identified some common themes and threads in the experiences of this group, and these issues are likely to resonate with others working in the public sector elsewhere in the country. It is also worth noting that a recently published Scottish Government review of progress on health and social care integration highlights many of the same issues raised in this report.

**General perspectives on integration**

7.4 Interviewees suggested that integration will look quite different depending on where you are in Scotland; indeed, they suggested it may look different depending on where you are within a single HSCP area. This is partly because the pace of change – although seemingly very rapid everywhere – is nevertheless slightly different in different areas. More importantly, it is because different HSCPs have different priorities, and even where they have the same priorities, they may be addressing them in different ways. Integration has brought with it a much greater emphasis on designing services that are tailored to the needs of people within small geographical localities. This means there will inevitably be variation in the way services are delivered because the needs of the people living in those localities are different.

7.5 Despite the many challenges and difficulties interviewees highlighted in relation to the ongoing process of integration, there was nevertheless widespread support expressed about the current direction of travel. With few exceptions, the interviewees who took part in this study saw integration as desirable and necessary. In fact, they pointed out that integration has been seen as desirable and necessary for a very long time, but efforts to bring it about without the force of legislation have not been entirely successful in the past.

7.6 At the same time, executive managers and senior managers emphasised that integration involved more than simply moving staff employed by different organisations into the same room; it required a change in organisational culture. One interviewee called it ‘a change for a generation’. While interviewees generally believed that things were moving in the right direction, they also acknowledged that change will take time, and it would not necessarily be an easy ride.

**The challenges and successes of integration**

7.7 Irrespective of their role and where they were based in Scotland, interviewees pointed to three issues – (i) organisational challenges of various types (including a lack of clarity about who has authority, decision-making power and budgetary control in IJB / NHS board areas), (ii) cultural barriers between NHS and local authority...
staff, and (iii) the unrelenting pressures of economic austerity – these issues were shared among all the interviewees in this study. Notwithstanding the point made above that the findings of this study cannot be seen as ‘representative’ of the public sector more generally, these same issues will undoubtedly sound very familiar to people working in the public sector elsewhere across Scotland.

7.8 Interviewees also pointed to some early successes – and the successes often related to challenges that had been overcome. For example, while some interviewees reported strains and tensions in relationships between the IJB and NHS board; others reported having worked hard to develop good relationships and a clarity of purpose among those involved in the strategic planning of services. While some interviewees commented that there was a great deal of ongoing confusion and / or even resistance among front-line staff in relation to working in new ways with colleagues from other disciplines and in other sectors; others reported that staff in some services were starting to become more comfortable with the idea of a line manager who was not from the same organisation that they worked for. While some interviewees talked enthusiastically about a new energy and a shared vision among those involved in the strategic planning of services, others commented that perhaps that energy and shared vision had not yet filtered down to those on the front line of service delivery.

7.9 At the same time, interviewees also said that greater progress in integration was being limited by the current challenges. The very specific challenge of how to bring the acute hospital sector onboard with the integration agenda may remain unresolved for some time, although part of the solution may involve addressing the problems associated with the way set-aside budgets are being calculated and used.

7.10 The cultural barriers between NHS and local authority staff will also take time to be overcome. Some interviewees suggested professional training and education programmes may hold the key to overcoming them, and they suggested there was a need to introduce the concept and practice of integration as early as possible in the training and education of the workforce. Some thought that professional education (particularly the training of doctors) had not yet caught up with the integration agenda. Others suggested there were practical, shorter-term solutions too – such as having a single, shared IT and HR system.

Involvement of the third sector in the integration agenda

7.11 One of the intentions of the 2014 Act was the third sector should be represented on IJBs, and that the third sector should be included as partners in integrated services. This study has provided a picture of how this is happening in different parts of Scotland.

7.12 Not everyone who took part in this study was able to comment on how things were working in relation to the third sector’s involvement in the integration agenda. However, some had experience of working directly with colleagues in the third sector to develop new service models, and others had experience of the third sector being involved at a strategic planning level. In general, interviewees with these kinds of experiences spoke highly of the third sector organisations they were familiar with – and they pointed to specific examples where the third sector was delivering services and or other initiatives that had a focus on (i) prevention, (ii) early intervention, and (iii) supporting people with multiple long-term conditions to stay well. At the same time, interviewees also recognised that the funding for this type of work was most at risk when there were multi-million-pound budget shortfalls within an IJB.

7.13 One of the interesting findings from this study was in relation to the diametrically opposite views expressed by two executive managers in different parts of Scotland about the role of their local Third Sector Interface organisation on the IJB. One individual believed that the TSI – excellent as they were – could not possibly be expected to be closely familiar with, and represent the interests of, every one of the third sector organisations in their patch; while the other wanted the local TSI to do precisely that. The extent to which TSIs are able to do this is, no doubt, affected by a wide range of factors, including the geographical size of their area and the number of third sector organisations operating in their area. However, the degree to which TSIs are familiar with the full range of third sector organisations in their area may be having significant implications for those organisations – given that pressures of time and money, and public procurement rules (relating to conflict of interest) are preventing individual third sector organisations from having a more direct role in IJBs (at least in some areas of Scotland).
It does appear, though, that some local areas are finding ways to work around these issues by involving specialist third sector organisations on project and programme steering groups.

**Involving communities, people who access services, and carers**

Examples were given of services being co-produced with people who access services (including those who have previously accessed services) and carers. Examples were also given of participatory budgeting exercises, with communities being given funding to spend on their own community chosen local priorities. Such initiatives are positive, but interviewees acknowledged that the extent to which they were happening was variable. Interviewees said that there was an increasing focus on such initiatives, but that the capacity was not always available to make them happen.

At the same time, there was evidence that IJBs were taking seriously their duty to provide training and support to service user and carer representatives on the boards – so that these individuals felt valued and could confidently fulfil their roles.

**Focus on prevention**

The findings of this study suggest that prevention (including early intervention, and self-management) are increasingly becoming a focus for service planning. However, interviewees also admitted that local financial circumstances are continuing to make it difficult to move beyond a position of ‘firefighting’. The ability of HSCPs to ‘spend to save’ may depend partly on whether the acute sector can be better integrated with community services – but it will also partly depend on whether ordinary members of the public can be persuaded to take more responsibility for their own health and wellbeing.

**Conclusion**

Health and social care services continue to be delivered in Scotland against a backdrop of ongoing austerity. To some extent, austerity is providing an impetus (though not the only impetus) for service transformation; however, it also has the effect of constraining the options for new and innovative service models. These pressures are likely to continue and may be compounded by changes in the workforce brought about by Brexit. For integration to be a success, an ongoing commitment to its aims will be necessary – not only from the public sector, but from the third sector, and from ordinary members of the public – for some time to come.
Annex 1: Methods and sample description

This annex discusses the methods used to conduct the research and provides a description of the sample – i.e. the interviewees who took part.

Overview of methods

This study used a narrative research methodology. An interview topic guide was agreed between the researcher and the ALLIANCE. This comprised a small number of open questions which were intended to give the interviewees space to discuss their own perspectives and experiences of integration. The interviews were recorded and transcribed, and analysis focused on identifying the main themes within interviews and common themes across interviews. Quotations are used extensively throughout this report to illustrate the main issues raised by the interviewees – and in order to allow the voices of the interviewees to be heard.

Recruitment of interviewees

This was a small qualitative study, involving interviews with 14 individuals. Interviewees were recruited in three ways. First, the ALLIANCE contacted individuals working in the public sector who were on their mailing list and with whom they had recent contact, and invited them to take part in an interview. A participant information leaflet, providing details of the purpose of the interview and what it would entail, was attached to the email invitations. If the individual agreed to take part, their name and contact email address was passed to the researcher for follow-up. Altogether, this process resulted in the recruitment of 11 interviewees. Second, the researcher contacted Social Work Scotland and a copy of the participant information leaflet was sent out to social work team leaders across Scotland with an invitation to take part in an interview. This resulted in the participation of two further individuals. The fourteenth, and final, interviewee was recruited through the researcher’s own professional network.

Description of the interviewees

Interviewees included:

- Executive managers (chief executive of HSCP, chair of IJB, deputy director of public health)
- Senior managers (integration manager, service transformation manager, programme managers, managers of Allied Health Professionals, public health manager, quality improvement leads)
- Team leaders (operational managers of integrated services within a locality, including services for older people, people with addictions, and people with a learning disability or autism)
- Front-line staff (delivering locality-based integrated services).

The sample included interviewees from both geographically large and geographically small IJB areas, and both urban and rural parts of Scotland, including one island IJB.

Note that every effort was taken to ensure that interviewees could speak anonymously; therefore, specific information about any individual’s job title or the localities they worked in are not provided in this report. Nor are quotations attributed to any particular individual.

About the interviews

Interviews generally lasted 30-45 minutes (two were slightly longer than this), and were conducted by telephone (in one case, the interview was face-to-face). Interviews focused on:

- Interviewee’s experiences of integration to date, including:
  - Successes
  - Challenges
  - Involvement of third / independent sectors
  - Support for integration / change at a local level

What difference is integration making, in terms of:

- Involvement of people who access services (and unpaid carers) in planning and development of services
- A shift towards prevention / anticipatory care

Note that interviewees often spontaneously raised other topics too. Some interviewees had careers which spanned two or more decades, and so were able to share a wider, and long-term perspective on the delivery of health and social care. All interviewees commented on the current direction of travel regarding integration.
We Need To Talk About Integration
Health and social care integration: How is it for you? Views from the public sector

Independent research commissioned by the Health and Social Care Alliance Scotland
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