11 July 2013

Dear Angiolina

ALL HANDS ON DECK

You asked me to explore how best to ensure that the full range of stakeholders are actively engaged in health and social care integration, with a particular focus on localities. I and colleagues have discussed this issue with a wide range of people over the last few months and our thinking has informed the draft Bill and other policy developments. I have also drawn up the attached report setting out my thoughts.

The first paragraph in the conclusions box is important, explaining the status of the document. I would expect this report to act above all as a stimulus for further debate, especially at the local level. Whilst the conclusions do not yet constitute formal Scottish Government guidance, they reflect conversations in the Bill Advisory Group and elsewhere and, I believe, have widespread support. Therefore in pressing ahead, as they must, with preparations for integration, local and other interests would do well to be steered by the material set out here. In other words, this report, which will be placed prominently on the Joint Improvement Team (JIT) website [], is both a resource to inform local discussions and the likely basis for our guidance and statutory instruments later in the year. JIT, working with colleagues, will be offering to hold events around the country to facilitate local discussions on local solutions and, importantly, to glean experience from the ground which will help fine tune the guidance and statutory instruments as they emerge.

There is a good deal of material here. I hope that readers will be struck above all

- by the need for effective stakeholder engagement at every level,
- by the vital importance of localities and the potential they offer if done well

Note re integration of health and social care-11.6.131
by the need to press on with preparations and
that, with many examples of really good practice from all around the
country, successful integration will be challenging but achievable.

I will leave it to you to decide how to take forward the specific recommendations. One final point here: the locality work does not sit in isolation. It needs to be seen as integral to both the partnerships themselves and strategic commissioning. Localities make no sense if either of those other elements is not considered at the same time. In taking this work forward, it will be important that there is clear coordination between this work, that on partnerships and that on strategic commissioning.

Thank you for all your support.

FRANK STRANG
Deputy Director

Copy list

Members of the Bill Advisory Group
Members of the Health and Social Care Management Board
Members of the Health and Community Care Delivery Group
Elma Murray, Chair - SOLACE
Gerry Marr/Richard Carey – for NHS Chief Executives
Partnership Leads (via JIT)
Staff side
All Hands on Deck

Health and social care integration: how everyone can play an active part in improving life for people in Scotland

This report sets out emerging conclusions on how best to involve the full range of stakeholders in health and social care integration. It refers in particular to localities, which must be up and running effectively by April 2015, but is relevant to all levels. This is not formal Scottish Government guidance. It is, however, likely to inform such guidance over the coming months. The different players – national but particularly local – will therefore wish to take these conclusions into account as the pace of preparation quickens.

Conclusions

The general principle

1. The scale, complexity and nature of integration mean that the challenge will only be met if everyone plays their part in full. The principles of good partnership working must apply at all levels.

Setting the framework

2. There is work to do to get localities recognised for what they are: the engine room of integration, centred on people and the communities they live in. It is not too early to plan for localities: if they are made to work well, there is every chance that successful integration will follow. A straightforward national framework for localities - provided it is sensitive and proportionate - can unleash local creativity, leading to better local solutions. It should require the establishment of effective localities, set principles and warn of unintended consequences, but to unlock local potential the emphasis must always be on flexibility for local design and local delivery. The centre should concern itself with outcomes, not process.

3. Localities need clout. A key factor will be the extent to which Health and Social Care Partnerships (HSCPs) allow for local decision making on delivering outcomes. We should not set national requirements nor deadlines but set the principle and describe the areas which we expect to be decided locally. We should require HSCPs to set out publicly the respective roles and the dialogue they have had with local interests to secure agreement. This needs to go hand in hand with clear accountability, both to HSCPs and communities. This should include local outcomes, transparency re data - and therefore variation - and simple financial arrangements whereby localities reap some benefit in kind from easing pressure elsewhere. It should be a priority to work out how such arrangements would work in practice at both partnership and locality level.

4. This project needs to lead to improvements within each of health care and social care. For the former, it must facilitate stronger integration of healthcare itself: all will have to adjust, with a more community-facing acute sector, a primary care sector taking more responsibility for system wide issues and an increasing blurring of the boundaries. For the latter, it must facilitate a social care sector combining effective delivery of its traditional core role with a focus on preventing ill-health.
Conclusions (continued)
Preparing the way locally

i  Short term
5  Good quality dialogue locally, especially - but not only - between professionals, is a pre-requisite. It must not be left until all the enabling legislation is in place.

6  Decisions on locality boundaries must not be allowed to drag on. There may be a need to agree a deadline. Whilst there are several criteria to consider, they should wherever possible relate to natural communities.

7  Localities will take time to mature and need to keep their eyes on the medium term. But they should think proactively about early wins, starting small with things which are achievable and desirable in the local context. Local experience of the Change Fund implies that in many places rapid access to home care may be a front runner.

ii  Medium term
8  Professionals, communities and users must always play a prominent part. But above all, localities should be solution-led. They must not be the servant of structures but focus creatively on the balance between implementing well the solutions already in place and developing new and innovative solutions. That mindset is as important as job titles.

9  Embedding the right cultures and behaviours is vital. Discussions on culture need to have a local focus and go beyond aspirational words. Mutual respect should include recognising what each partner brings to the table and how each needs to change. Being person-centred needs to include being willing to take risks; and localities need to embrace confidently local history and aspirations.

10  HSCPs must operate as strong allies of Community Planning Partnerships (CPPs) - and vice versa. We cannot afford duplication of effort, either for the public or for public services. With clarity on their roles, they can reinforce each other, with CPPs key to HSCPs’ delivery - and HSCPs adding real value to community planning.

Support
11  Partnerships will need adequate support if they are to deliver these aspirations. Fiscal realities mean that this will need to be well targeted, including the following
•  Local design will often work best with tailored support. The Joint Improvement Team, working with others (see para 41), should be tasked to offer events helping local players to develop local solutions. This will be about energising, informing and facilitating local thinking and culture change. But local thinking must not be left until such an event.
•  Whilst there may be a case for targetted transitional capacity/resource to enable stakeholders to kick-start localities, all partners need to recognise that ultimately this will not be something they can choose to opt out of: working with others in new ways to deliver well integrated care is simply what we all now do.
•  Experience points to the need to keep our eyes on operational issues. More attention must be given now on to issues around data-sharing and compatibility of IT systems.
•  Streamlined mechanisms are needed to ensure that research, evidence and innovation, originating at whatever level, are made widely available to inform local choices. Given the focus on prevention, this is especially relevant to public health.
•  Effective leadership will be required at all levels. NHS Education for Scotland and the Scottish Social Services Council need to give early thought as to how existing resources can be developed into a more integrated resource, to be delivered jointly.
Introduction

1 Integrating health and social care in Scotland is a mammoth task. Getting it right matters to many people: to those receiving currently such care, including some of the most vulnerable in our society, to the professionals in our care systems, to those who hold the purse strings, to the advocates of public service reform, and, ultimately, to all of us as we see ourselves and our loved ones move on in years.

2 This report does not make the case for integration. It takes as read that we are all signed up to the urgent need to reshape care for adults in Scotland. Nor does it seek to cover every outstanding issue. It focuses instead on what I believe to be absolutely central to this whole endeavour: doing all we can to ensure that all those with any interest can play a full and active part. It focuses in particular on how we can make a success of the locality level.

3 Integration is a long term task. It is a well-known aphorism that there are two possible outcomes for anything involving culture change: it will happen either very slowly or not at all. As iMPOWER said in its recent report, “..Whether health and care reform in Scotland is a bureaucratic challenge or a genuine reform lies delicately in the balance”: it is our task to make sure it is the latter.

4 This report is not the final word. It represents the impressions we have gleaned from a series of conversations over the last few months. I have sought to resist the alleged civil service temptation to sit serially on the fence and have given where I can a sense of direction to serve as a stimulus for debate. Just as many of the solutions to our task should be co-produced, so should much of the system as a whole. I am very grateful to all those who gave me their time – the list is at Annex A. I have also sought to build on the principles at Annex B which were agreed last year by the key stakeholders.

5 Nor is this the first such report. A good deal has been said and written on the subject. More importantly, a good deal is already being done. I have sought to weave through the text examples of where the key elements of integration locally are already in place. This is just a tiny snap shot of what's already out there. What that means is that we do not need to be daunted by this task: the key ingredients are already in place in locations around Scotland.

6 A key issue is whether any national framework can add value. For some, locality work is entirely a local matter and the priority is to let local creativity flow: the best that can be hoped for from a Scotland-wide document is that it does little harm. Others are looking to be told firmly what's what. In my view, a national framework, provided it is sensitive and proportionate, is just what is needed to unleash creativity and lead to better local solutions. No doubt neither side will be entirely happy with the attempts I have made to tread the fine line between the two. But I hope the report serves as a compass to help prepare the way for successful integration.

1 http://www.impower.co.uk/public/upload/AQuestionofTrustMay2013.pdf
Remembering the Why

7 If we all have clearly in our mind what it is we are trying to achieve, there is a good chance the rest will follow. Put differently, if some aspects of the partnership and locality arrangements are implemented less than perfectly but the outcomes are delivered, then those successful outcomes must take precedence. The outcomes can be expressed in different ways. The final wording of the national outcomes will be refined over the summer: the latest version is at Annex C. More generally the Bill sets the overarching principle behind integrating services as being to “improve the wellbeing of recipients”.

8 Everyone will have their own why. Some will be above all aware of the stark demographic and budgetary figures; others will want to give momentum to community planning; but most obviously we all want to do the best we can for our mothers, fathers and friends and the most vulnerable in society. There are of course other aims, possibly less critical, but nevertheless equally valid. These include:-

- **Community empowerment**: creating capacity in communities, not least by helping to give a new lease of life to community planning;
- **Professionalism**: enabling professionals and others to fulfil what it is they came into the profession for;
- **Dying well**: weakening the taboo on talking about death, allowing people more say over where and with whom they die;
- **Rights and responsibilities**: altering the relationship between the individual and the state and between professionals and the individual.

9 Personally I’m often helped by stories, bringing to life what all this can mean for individuals. There are many versions of these, with good examples of partnerships (e.g. Borders) articulating their plans around particular individuals/case studies. We could do worse than keep in mind the stories of individuals such as those who have benefitted from the examples in this note: e.g. Heather from Glasgow at footnote 7, Mr Orr from East Ayrshire at footnote 5, Ingrid from Orkney at footnote 14 or Mr and Mrs Powers from Lanarkshire at 17. Delivering successful integration is not about well drafted commissioning plans or smooth running committee meetings, but about a flood of examples such as these springing up throughout Scotland.

All Hands on Deck

10 My premise is that integration is everyone’s business and needs everyone’s input. The Bill, as a statute, focuses on the limited things which statutes can do – primarily dealing with statutory issues and bodies. That should not mislead or distract us. If Scotland’s older people, over a quarter of the population by 2033, are to live in dignity and well then a vast range of people will need to play their part. That of course is the whole point of integration, but we need to interpret that widely. The task is simply too big to be left to one group or another; it is about not only health and social care integration - challenging enough as that is - but health integration, local authority integration, community/professional integration and so on. Therefore hospital consultants, housing managers, community activists etc. all need to be involved as well as primary care teams and social workers. So we need all hands on
deck. Before confirming the name for this report, I was asked to think carefully of the Titanic…I have and I stick to it. We at least have ample warning of the iceberg and can take steps to steer clear of it. Those who choose not to be on deck will not be neutral; they may actively – knowingly or not – be making it harder for us to turn the ship, to achieve the changes we so desperately need.

11 A few clear high level principles should apply here. Those articulated for example by the Joint Improvement Team (JIT) and for Community Planning Partnerships, although designed for more formal partnerships, are all relevant: this is more about partnership than traditional stakeholder engagement. We should not be bamboozled by the different wording. The key ingredients are ultimately straightforward, including

- openness, trust and honesty
- agreement on shared outcomes
- regular, straightforward communication
- clarity on roles, governance and decision making

12 These principles matter. In avoiding over-prescription on the how, we must not give the impression that we do not care about the what. Whatever principles are agreed, we must make clear that they must be taken seriously throughout the project. This report says what that might mean.

13 This report focuses mostly on localities. This is the level at which there can be the most effective engagement of the key players. But I am acutely aware that many feel they have enough to do to create partnerships (or “Integration Authorities”) – and that localities without partnerships mean nothing: the two need to be developed in tandem. The principles need to apply at all levels, whether national, partnership or at the level of individual cases. For partnerships, even if the formal voting rights on the Integration Board are for the statutory bodies who hold the budgets, ways need to be found – as they have been in other forums – for all other parties to feel for all intents and purposes full members. Importantly, they must be and be seen to be full partners in the commissioning group and process. This is not a one-way thing. The different stakeholders need to come to a mature view on the level at which their input would be most beneficial; not feeling that they need to put equal effort into being heard at each. The view they take should be formed above all on the basis of ability to add value in regard to the shared outcomes – and on trust in the process. The last thing we need is too many Captains on the bridge.

Localities

14 To make localities work it is essential to be clear what they are for and why they matter. Again, once this is clear, form will follow. The Bill says very little about localities. Very few of the existing commissioning plans even mention them. They therefore need to assert their value, and others need to grant them their place.

15 Localities will be the population of a geographical area somewhere above the catchment area of, for example, a general medical practice and below the population of the HSCP. This level is described variously as the key building block or the engine room of integration. It matters for a variety of reasons. In line with the
Christie Commission, it brings the project down to a local population around whose needs genuine integration can best occur. That is a vital principle. It maximises the potential for harnessing a local sense of identity and, crucially, those solutions based on local resources which may make or break this project. It allows for a focus on tackling inequalities. It is the level at which it is most conceivable to take decisions on the kind of practical change which can effectively reshape care. It is the level at which the key practitioners are likely to be known to one another – and at which there is the best chance of solutions being acceptable to the public. For all those reasons it is the level at which we stand the greatest prospect of effective proactive engagement from front line practitioners and the community. A focus on localities is in part a proxy for engagement with stakeholders.

16 Done badly, localities will add little value. We need to avoid a variety of pitfalls. If we are too demanding, HSCPs may simply create the minimum they can get away with and react in a tokenistic way. If we allow hermetically sealed, parochial localities we may lose sight of issues which cross localities and cause unnecessary disruption to well functioning teams. The lines in the map are about a population and its needs, not about how services themselves are structured. A population’s needs can be met in a variety of ways, delivered at a variety of levels. If we make localities too weak they may wither on the vine, with professionals and others voting with their feet. On the other hand if we get this aspect right, much of the integration agenda falls into place, with genuine reshaping of care on the basis of clinical, community and voluntary solutions, leading not only to better outcomes for individuals but to communities growing in confidence and capacity and practitioners being more fulfilled in their role.

What Do We Mean by Getting This Right?

(i) Right Lines on the Map

17 The Bill does not say where to draw the line. That is as it should be. No aspect is more amenable to local differentiation. However we must avoid a lengthy, sterile discussion locally over territory. That would be unproductive and divisive and would stall the vital preparatory work. We therefore need to give a timetable and some clear criteria to guide partnerships in their choices (stressing that things need not be set in stone: if experience shows that the boundaries need to shift on the margins, then partnerships should not be afraid to do so). The overall steer should be to seek to identify the communities into which the area naturally divides. In many places that will be obvious. Beyond that, HSCPs, working closely with CPP partners, should be guided by criteria such as socioeconomic/demographic homogeneity; effective grouping of general practices (in other words, using GP clusters as the basis will not be a requirement but may well commend itself in some locations); linkage with secondary or intermediate care infrastructure; local authority wards; social work team areas; school catchments; CPP local areas; clustering of health issues/conditions; and, crucially, history. They may also choose to operate some localities of interest in addition to geography. Above all, partnerships need an inclusive, speedy process to get to this point so the real work can begin.
(ii) **The Right Role**

18 How to draw the line will depend on just what localities are for. Very little has been said about this so far. I would see their role in broad terms as being to:

- feed into the strategic commissioning process a collective view on what needs to be made available in respect of their locality
- on an on-going basis decide on proposals from local professionals, users and communities on ways to improve the delivery of services for the locality.

19 How they do that will vary hugely, But I would expect them in every place to promote the integration principles set out in the Bill, including reshaping care towards greater prevention and anticipation, and, more specifically to undertake their activity in such a way that:

- decisions on the delivery of the services set out in the Partnership’s strategic commissioning plan reflect local needs and resources;
- the strategic commissioning plan takes account of the different needs of different people in the area;
- the most effective and efficient use is made of the range of resources – not just those that belong to the HSCP – available to the locality; and
- there is appropriate on-going engagement with local professional and other leadership.

20 The third point merits some explanation. This is in part about new solutions ensuring that all local assets and resources are taken into account. This may be about creative use of third sector bodies on co-produced solutions; it may be about active engagement of the right professionals to develop new ways to deliver the enablement and rehabilitation which are core to this project. A current example is at \(^2\) below. It is also about efficiency. However we approach this task, we cannot avoid the stark fact that we are talking largely about how to secure wellbeing with tighter finances. Here are examples in the context of delayed discharge: \(^3\),\(^4\). That has implications for the expectations we set for this project. It also means that we must take seriously the need to do what we can to adjust the expectations of individuals as to the balance between state provision, provision by others and self-management. There are many examples of this shift, with increasing capacity and resilience in the community; below are links to a few: \(^5\),\(^6\),\(^7\),\(^8\).

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\(^2\) http://www.jitscotland.org.uk/downloads/1331807761-So%20much%20more%20than%20just%20another%20Lunch%20Club%20NHS%20Tayside%20Final.doc


\(^4\) http://www.jitscotland.org.uk/downloads/136498885-Borders%20CCB%20CP%20Case%20Study%20Feb%2013..pdf

21. Discussions on role will inevitably cover whether to include anything on children. In formal terms this will depend on whether they are part of the integration plan. Even if they are not, partnerships should actively consider the interaction. The way in which localities are delineated for adult care will have implications for how children’s services are delivered. Moreover, in many places the integrated approach being taken to children and early years has much to teach adult care. We should not let the question of formal inclusion hinder the scope for possible helpful synergies.

(iii) Right Powers

22. The most important step for effective localities is to give them adequate power. In other words

- Partnerships must agree with their localities, local expressions of relevant partnerships outcomes. In order to be able to define and monitor these, localities will need access to good data, on for example costs, activity or public health.
- Partnerships must give localities a transparent means for influencing their strategic plans, reflecting needs assessments and users’ views. This will involve ensuring localities have an effective means of coming to a collective view on priorities.
- Above all, localities must have clout. Partnerships need to give localities the power to take decisions on significant proportions of local spend and activity. Even if there is no formal delegation of budgets – which partnerships can choose to do, but are not required to – this means identifying areas where the default position will be that localities’ views on budget allocations will be expected to apply and where localities will be empowered to adjust the way resources, once allocated, are deployed. Whilst the scale may well grow over time – and needs careful caveats around involvement of the partnership level - we need to be clear about the principle from the outset. This will be one of the trickiest issues. In an ideal world partnerships would be so seized of the merit of localities and localities of the merits of the wider view that the perfect balance will be agreed locally. But the world is not ideal. Just as Voltaire refused to tolerate the enemies of tolerance, many would argue that there should be no autonomy for the enemies of local autonomy. That would imply policing a minimum percentage of money and activities which must be delegated to localities. However, that would lead to tokenism and possibly the delegation of the bare minimum. In any event, places will differ enormously. Therefore I recommend that we spell out as a requirement the principle articulated at the start of this paragraph but leave the detailed how largely to local discretion. We should describe the kind of services where we would, over time, expect local decisions and require HSCPs to set out publicly the

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7 http://www.jitscotland.org.uk/downloads/1364988729-Glasgow%20CCB%20CP%20Case%20Study%20Feb%202013%20no%201.pdf
respective roles and the dialogue they have had with local interests to secure agreement and to explain, for those areas they have decided not to include, why not. We could also encourage partnerships to consider identifying meaningful sums of money ear-marked for localities to develop new solutions. This should not be black and white: in exercising those functions which are not formally delegated we would expect partnerships to find ways of involving localities; in exercising delegated functions we would expect localities to take account of wider issues. In other words we all need to think more geographically. The experience of developing clusters in Aberdeen shows how it is possible to combine effective localities with responsibility for spreading good practice partnership-wide.

23 All this means we must get right the relationships between localities and partnerships. There is a strong case for putting some effort into articulating, if possible visually, how the different layers interact, from national outcomes, to supra-partnership commissioning to partnership commissioning, to locality planning to individuals’ input, (taking account of self directed support). The very fact this won’t be easy is why it’s worth doing.

24 It will be important also to be clear about relationships with community planning partnerships (CPPs) and their infrastructure. The SG response to the consultation makes it clear that the relationship will not be hierarchical. Many have welcomed this, not least those who do not believe that CPPs are yet delivering to their potential. However, in my view we cannot afford distance here. Ministers have made clear their ambitions for CPPs; community engagement has a new lease of life under the Community Empowerment Bill. We cannot afford duplication of effort, either for the public or for public services. In those places where integration is working well there appear to be clear, unambiguous linkages with the CPP at the partnership and locality level, with an appreciation on both sides of what the other brings and where each can add value. This is not about who is the Captain but about designing things so that:

(a) There is a clear line of sight to outcomes in the Single Outcome Agreements. This will involve joint ownership of the outcomes and clear responsibility for keeping CPP structures informed of progress.

(b) There is ready access for HSCPs to CPP resources such as effective community development and public engagement, an influential voice for HSCPs in respect of housing, transport, education etc. and an ability for those services to influence the work of the HSCP.

(c) Above all, the population of the locality sees one process of engagement not a plethora.

25 CPPs themselves will need to adjust to this new world, engaging with HSCPs as genuine partners, who have a legitimate say over much CPP activity. In return the partnerships will give CPPs real momentum on the ground, delivering in practice what community planning is really all about. In other words, not a distrustful stand-off but a genuine local synergy.
(iv) **Right Accountability**

26 These powers will not stand the test of time without clear accountability. We need to tease out what this means. We should be clear that formal responsibility for strategic commissioning will rest ultimately with the HSCP. Equally it will be in the gift of HSCPs to adjust locality arrangements which fail to deliver. Since we do not have local financial commissioning and are dealing mostly with people other than state employees, local accountability will not be primarily about financial rewards or job losses (or promotion...). But that does not mean there can be no accountability. In the real world we have achieved satisfactory accountability without pulling these levers. We need to use other approaches.

27 This is partly about transparent setting and monitoring of local outcomes. Public knowledge of success or failure is a powerful accountability for some. It is also about intelligent, objective use of data, on activity and on resources consumed by any given population. This will highlight variation, teasing out which is warranted and which is not. Perhaps most important will be finances: partnerships – and in turn localities- must reap in broad terms benefit from efficiencies gained elsewhere (and some disadvantage from the opposite). In the light of the data on variation there will be very real peer pressure on those whose behaviour is outlying in terms of risk aversion - the net effect may well be increased pressure on acute and therefore less local resource for community-based solutions. Whilst the principle of this virtuous cycle may be difficult to implement in practice, it is nevertheless important. A priority will be to work out how best to achieve this without over-complication or unhelpful competition.

(v) **Right People**

28 Many are tempted to boil the debate down to who gets a say on what. This preoccupation is only natural but the suspicion which lies behind it illustrates well how far we have to go in developing trust. In part this relates to history. At various stages different players have felt left out: GPs and carers under CHPs; other clinicians under LHCCs; all local players under the Joint Futures Fund. This pendulum lies behind our talking about “professionally-led localities”. There is no doubt that we must have better professional involvement than in many CHPs – not only in responding to propositions but in identifying, shaping, deciding on and delivering the crucial changes required (hence the key importance of the word “involve” in section 32 of the Bill) - but no-one is advocating a full swing of the pendulum back to where it was. Ultimately, we want integration, and therefore localities, to be led not exclusively by one group or another, but by those who have a focus on and ability to deliver solutions. They should be solution-led. Any other articulation is unhelpful. Put another way, they must not be the servant of structures or processes but rather focus on achieving the right balance between implementing well the solutions already in place and developing new solutions.

29 The who question therefore revolves around attitudes and aptitudes as much as job titles. With the right attitudes and the right culture, a range of different combinations of people can be made to work. This puts a premium on developing the right form of leadership. There are several blueprints. One option is that the resource being worked up for primary care by NES/the Royal College of General
Practitioners/Royal Pharmaceutical Society could be taken as a starting point and, working with the Scottish Social Services Council, developed from the perspective of integration. I would expect the qualities to include on-going clinical/professional involvement, representativeness and active connections to the locality. The key here will be not just to ensure that the different professions/players have the same type of leadership training but that they participate together. This will be particularly important for the core professional alliances, such as that between GPs and social workers.

30 It is tempting to leave this discussion there. Provided the right skills and attitudes are in place, the rest should follow. We certainly do not want to go for a full list of who should be involved - the death knell of any locality planning. That would simply risk replicating the tokenism of many CHPs. In our rigidity we, ironically, risk missing out some of the best people to drive change locally. But we would be derelict in our duty if we did not give some steer not least so as to spare localities from having to spend all their time on the who and the how. We do not have the time to reinvent such wheels. I therefore recommend that:

- We stress to partnerships the flexibility which they have on how to do business in localities. We are not mandating any particular approach. They could decide to put in place standing formal committees but they need not do so and could consider some form of variable geometry. Management’s role will be about facilitating creative and dynamic solutions as to how the principles should be delivered.

- There is a strong case for thinking differently about the two principal locality functions:

1) contribution to partnership planning: here we would expect the full range of interested parties to have the opportunity for substantial input, including users, health professionals, social care professionals, carers, third sector, the independent sector, locally elected members, housing interests etc. This should include very clear linkages with CPP processes and Community Councils. This could involve some degree of formality and partnerships might consider holding meetings in public.

2) decisions on delivery: we would expect decisions on reshaping care locally always to involve both users and those most involved in directing and delivering care, in particular those most likely to be able to generate solutions to reshape care. In practice, we would expect users, social workers, GPs, nurses, AHPs and the third sector to be closely involved in all such decisions, with geriatrician input where there is potential secondary care impact. We would expect a wider range of other stakeholders – including but not only community pharmacies, locally elected members and carers and other health providers - to be involved in such decisions as appropriate and to be kept informed regularly of decisions taken. Localities will want to ensure that they are alive to solutions offered by those whose structures happen to be such that they are not immediately visible at the local level – examples include mental health teams and AHPs.
• Partnerships are encouraged to experiment with processes. They should try certain permutations, test the reality against the principles and be prepared to move on as circumstances change.

(vi) Right Support for Stakeholder Involvement

31 Many say that even if we get all of the above right, the whole edifice will collapse because stakeholders lack the capacity to engage. This needs to be taken with a pinch of salt. It is what you might expect already hard-pressed stakeholders to say. Integration is not a nice add-on which government has chosen to dream up. It is a fundamental shift, endorsed by all, in how we all deliver the bread and butter of what we do. We should have no truck with the reaction – however human and understandable – “How are you going to make this in my interest?” Working with others in new ways to deliver well integrated care is simply what we all now do.

32 There are nevertheless serious issues here especially in the short term. The third and independent sectors appear in some parts of Scotland to lack the capacity to engage well in delivering solutions. GPs and other health care providers in the community are already struggling under the demographic change. Secondary care continues to be under pressure to meet stretching targets. Social work and nursing are being pressed to change in a variety of directions. The third sector are as cash-strapped as any. The key impediment to engagement will vary from group to group or indeed location to location. We cannot solve each issue but some possible areas of attention are:

• Partnerships should provide the necessary administrative and management support to ensure that the various representatives are able to perform these roles effectively. This will include data provision, creative use of technology, meeting agendas etc. It must involve ensuring that the circumstances are in place for clear, timely decisions and follow-through. The most effective arrangements currently in place appear to have bitten the bullet and employed locality managers. Localities and partnerships will also need expertise in needs assessments so that they can combine statistical rigour with profound local knowledge. Here’s one of many examples of where management has played a key facilitative role in delivering local solutions,9

• Time is of the essence. Given current finances, the first priority is to make the very best use of everyone’s time. Beyond that we need to consider how to free up time. This will mean different things for different professions/groups. Given their independent contractor status, there is clearly a need for some form of tangible support locally to allow GPs to participate without negative consequences for themselves or their patients (either as a core part of any new national contractual arrangements or as something more targeted outside the core contract). We will also consider the use of supporting professional activities (SPA) time for secondary care.

But similar considerations will apply for nurses, AHPs, social workers, housing officers etc.

- We need to be clear about the basis of each group's engagement. It might not be realistic for some, such as the third and independent sectors, to identify a formal representative; learning from the Change Fund suggests we might be talking more in terms of an advocate/gatekeeper and there may be a case for developing more community anchor organisations, such as some housing associations. More formal representation/mandating might be possible for e.g. nursing or general practice. All will need to make sure their own house is in order in terms of ready access to either views or capacity to deliver.

- Steps to bolster the confidence of professionals. Local engagement, which values generalism alongside specialism, will lead to some concerns about dilution of expertise. This may well lead to local inertia, the enemy of this process. We must therefore stress that there will be no compromises on the quality and safety of care and ensure that the clinical governance and oversight arrangements are such that local practitioners have the confidence to engage, comforted by a clear safety net.

33 Some areas have not yet been thought through in detail. This appears to include public health. There appears to be some reticence here. This is partly to do with capacity, but also a sense that public health issues affect wider populations, not just partnership-wide but regional and national. There is a fear that they may be ignored at the locality level. But localities are about taking a population approach. Moreover the whole endeavour of integration is about prevention, anticipation and behavioural change. They will enable partnerships to focus more effectively on health inequalities. These are all of great interest to public health. We need to find ways of ensuring a local focus on these issues. This should include access to good local data on public health issues, evidence of those interventions which are effective and access to expertise at the partnership level. This is a prime example of where significant local flexibility should go hand in hand with proactive efforts at a wider level to research and develop new approaches and promulgate them effectively.

(vii) Right Culture

34 I would have preferred to devote double the time to culture as to the who. Perhaps unsurprisingly it has often been the reverse. Culture and relationships are key – get those right and the rest may well follow; get those wrong and it certainly will not. This will be a huge mountain to climb.

35 Much has been written and said about culture. Cultural features are key elements of the JIT's integration readiness checklist, the CPP checklist and the work of the King's Fund. Words such as respect, recognition, valuing people's time, leadership and communication feature prominently. We do not need to reinvent a framework or start a new process. What we do need to do is to give this theoretical framework light and shade and its integration personality. This applies in spades to localities. It seems to me that some of the key cultural imperatives are as follows, with some indication of what they are likely to mean in practice:
• **Respect** – this comes at the top of most lists. But what does it look like? It clearly starts with appreciating the other. A key feature of our discussions has been to tease out what each player brings to the table. There also needs to be recognition from all sides that every player will need to adapt to make integration a success. Whilst I was tempted to set out the kind of things this might mean for each partner, it would not be appropriate to do so from the comfort of St Andrews House. The serious point of course is the simple fact that for each player there are these two sides. The different local players could usefully discuss their perspectives on these points. Tangible examples of respect have included a greater willingness to act on assessments made by other professionals and the use of corporate tools, e.g. performance management matrix, devised by others. Several players stressed to us the importance of “sharing a kettle” – for example\(^1\) below – i.e. the extent to which informal communication based on co-location can make relationships work.

• **Person centred** – this is classically about having the individual at the centre of every decision, thinking more of pathways than of systems. These remain vital. It is also about aggregating the experience of a number of individuals to draw conclusions about the reshaping which is urgently required in many places. It is about a willingness to both safeguard what is precious and try new approaches even where there is some risk. The recent report by the Scottish Parliament’s Local Govt. and Regeneration Committee on public service reform identified risk aversion as a key reason why reform may be stalling. Learning and managing risk go hand in hand with improving outcomes for people.

• **Outward facing** – partnerships and localities in particular will need to have a public profile, creative about serious community engagement and up for shaping public expectations, not just responding to them. We would expect them to be visible features of the local landscape taking pride in sharing its history and shaping its future. They will need to make integrated care relevant to individuals, making full use of the range of communications from circulars to social media. I don’t believe that it’s fanciful to hope that, if this is done well, with the full support of local politicians and others, the much-needed reshaping of care may be much less of a rocky road. Here’s an example of a project engendering such tangible local pride\(^1\).

• **The model of care.** We are integrating not only different activities but also different philosophies. For many there will be shift from a model based on ill health and decline, to one based on wellbeing and growth. In reality a slightly different model will be appropriate in different places. The key point is that we are aware of the choice we are making. We certainly need to be very careful about the language which we use, perhaps even with a glossary of the words that trip us up.

\(^1\) [http://www.jitscotland.org.uk/downloads/1331811008-Nairn%20ACP%2020160212%20Final.doc](http://www.jitscotland.org.uk/downloads/1331811008-Nairn%20ACP%2020160212%20Final.doc)  
36 These cultural issues apply to all parts of the system, not just front line localities/practitioners. The ability of partnerships to reshape care effectively will be crucially dependent on the willingness of the parent bodies to exercise facilitative leadership, i.e. to let go. That applies to the SG and the COSLA Leadership as much as to Health Boards and individual LAs. This needs to be multi-lateral if it is to happen at all. The unlearning involved here will be significant. Crucial to its success will be factors which reassure those parent bodies such as explicit local outcomes, transparent comparable data and clarity that there are areas where there is no intention of delegation. The more localised approach being adopted by the scrutiny bodies will help. We all need to learn that this is the world we now inhabit.

37 It would be a grave error to prescribe how these cultural points should be pursued. Again there is excellent practice out there whether action learning sets, joint events/training etc. Here is an example of the issues involved in creating a new locality team\textsuperscript{12}. Much of the joint work already done on reshaping care for older people means many areas stand in good stead. What might be appropriate would be to work together on a very simple checklist/questionnaire, based on the existing literature, against which partnerships and localities can shape their thinking as to what is most appropriate in tangible terms where they are.

38 We need to be aware of the importance of personality. Local stories are littered with references to the strength of character of two or three people. For example, the Third Sector worker behind\textsuperscript{13} below. That is real life. But we want to put in place something that will last for 20, 30 years or more, regardless of the individuals in particular places. That is why we must aim to have the right cultural features in place at every level and in every transaction.

(viii) Right Preparation

39 1 April 2015 will be here before we know it. The imperative for change is manifesting itself right now in our surgeries, care homes, homes etc. The need is urgent but the process of change will be slow and needs considerable teeing up, so we must start to get on with it now.

40 In part this is about getting the corporate ducks in a row. There is a long list of preparatory steps. The Highland experience tells us that we can never give too much attention to the practical operational angle. We need to give particular attention to issues around data and compatibility of IT systems. Whilst no-one should treat the lack of a single IT system as an alibi to stall progress, partners need to be clear how these issues are being taken forward as part of national and local time lines and where responsibility for progress lies.

41 Preparation will be particularly important in respect of localities, given the range of people involved. Again, it must be led locally. I recommend that the Joint Improvement Team, working with the Improvement Service, the Quality, Efficiency and Support Team (QuEST), the Health and Social Care Alliance and others, should

\textsuperscript{12} http://www.jitscotland.org.uk/downloads/1364989576-North%20Lanarkshire%20CCB%20CP%20Case%20Study%20Feb%2013.pdf

\textsuperscript{13} http://www.alzscot.org/campaigning/policy_reports/2099_facing_dementia_together_project
be tasked to offer events to be held around the country taking the principles and cultural points as set out above and helping local players start to develop local solutions. This may be an opportunity to communicate some of the key lessons in the improvement framework, but it will be above all about energising, informing and facilitating local thinking. As a by-product we would refine the principles themselves before they are cast in stone.

42 This process would also allow us to continue to populate best practice. This area merits constant vigilance. There remain a host of places from which we can draw good experiences but using them to best effect remains a challenge. We need to pull these together into a single resource, using new technology wherever possible. What I have learnt above all is the need to ask the right question of the data base if it is to be of use.

43 It is already clear that there are ways in which every single player needs to adapt. It will be for each sector to identify how. I offer below, as an illustration and for discussion, some thoughts on three areas, not because they are most in need of change (indeed these changes are very unlikely to happen if they are not matched by others’), but because they are those to which I have been most exposed.

(i) GPs

- No-one – whatever their view of general practice – is denying the centrality of GPs to this endeavour. The universality of their coverage, the holistic, person centred care and advocacy which they provide, their risk management skills, their role as gatekeepers, their influence in the community – all these will be vital. GPs’ involvement will be a make or break issue. Locally this fact is crystal clear. This will not be easy, in particular because of work pressures. This lay behind our willingness to negotiate separate contractual arrangements for Scotland last year with an emphasis on professionalism and a minimal increase in workload. Whilst GPs in reality have little choice as to whether to be involved in this endeavour, they do have a choice as to whether they will simply thole it as victims or shape and lead it. Whatever the exact terms of local engagement, GP leadership in various guises will always will be key.

- Constructive engagement in integration needs to be seen as mainstream. There needs to be transitional support mechanisms to free up the necessary time but in due course this needs to be seen as core activity. In any contractual changes we also need, where we can, to remove disincentives, in particular some of the condition-specific quality and outcome framework indicators which have served their time.

- Workload - we need to be better at quantifying where there is alleviation (or indeed worsening) of GP workload pressures through this process. We need to be better at identifying examples such as that at 14 below.

14 http://www.jitscotland.org.uk/downloads/1364989636-Orkney%20CCB%20CP%20Case%20Study%20Feb%202013%20no%201.pdf
• Change - Some of the changes likely to be required of GPs - as of others – will be relatively straightforward (to say, if not to do!) such as taking a community perspective, working increasingly in partnership etc. But integration should also be a trigger for more radical thinking about just how we deliver care, not least in primary care. There is much we lose at our peril, but there could be scope for a step change in, for example, how practices work together. Whether or not this is full-blooded clusters, closer working will make representation easier; make attachments in various guises a much more likely proposition; encourage greater professional support and might allow, for example, for better delivery of out of hours care. This is also a chance to test out in our circumstances other models, such as the ‘Nuka Model of Care’ as practised in Alaska. This revolves around fully integrated primary care teams, each serving a discrete cohort of patients and their families with a particular emphasis on long term continuity of care and quality human relationships.

• Building on what is happening now – GPs are already doing lots of this. All Scottish GPs are working in partnership with other disciplines this year on developing anticipatory care plans, together with action for those prescribed multiple medications: see 15 below. This work, recently lauded at the EU level, embodies many of the key features of integration, including regular multi-disciplinary discussions of individual patients, proactive sharing of plans and of course a focus on anticipation. With the right incentives and preparation, we can spread good practice quickly and well.

• GPs will be central to the vital objective of improving health integration, crucial to the clinician/clinician interaction which will allow this to happen.

(ii) Secondary care

• It is easy to forget that integration will be a big deal for secondary care too. We should not play this down. Whatever levels of acute spend are ultimately delegated to the integrated budget, all parts of acute will be affected. They need to be increasingly community facing with a focus on accessibility to primary care (e.g email/telephone advice). For some clinicians this will mean being prepared to spend more time in the community, whether in person offering surgeries, overseeing and mentoring other clinicians, partnering care homes etc. or virtually in taking a clinical interest in those in the community. We need an anticipatory secondary care service. There are of course many examples where this is happening now, e.g. 16, 17 and 18 below. It also means

15 http://www.jitscotland.org.uk/downloads/1331811008-Nairn%20ACP%202016%20Final.doc
16 http://www.jitscotland.org.uk/downloads/1371037223-VAL%20Hatch%20ICASS.ppt

Note re integration of health and social care-11.6.1319
managers being prepared to reorganise things so that secondary care can have its voice well expressed in partnerships and localities. Secondary care professionals are central to making this work.

(iii) Scottish Government

- The SG needs to deliver consistent messages, all based on the 2020 Vision\(^{19}\), with its stress on shift to community care and self-management. This needs to be obvious from our actions as well as our words. We need to be willing to accept more readily different solutions in different places. We need to be very careful about the targets we set, not abandoning the rigour and energy of the HEAT approach (performance management system based on targets covering Health Improvement, Efficiency, Access to Services and Treatment), but ensuring that the performance framework develops over time to reflect the emerging integration outcomes. We need to ensure that we adjust our existing practice to reflect the wider canvas of health and social care. This does not mean automatically extending everything to social care but considering on every occasion whether eg workforce strategies, health and social care management board business etc need to be adjusted.

44 We need to give as much attention to preparations in other areas, such as social care and the voice of users. The work of the Scottish Health Council will be important. We need to make sure that co-ordinating an effective users’ voice is not an afterthought. We need to have the same standards across the whole care system, but not spend a long time agreeing them. We need flexibility as to how these are applied in different places and we must not reinvent what is working well, in particular in the CPP context. Local authorities have many years of track record in this area. And we need to combine users’ input into future needs with users’ views on past experiences, finding effective ways of closing that particular loop.

45 There are some essential first steps. Here are two. Most emerging partnerships will no doubt have established regular dialogue with their CPP counterparts, including mapping out just what each is doing; if not, they certainly should. Second, the more encouragement is given to high quality dialogue locally between professionals and others the better. The experience of many localities is that such dialogue, however informal, was the bedrock of everything else. Exactly what the arrangements look like in due course will have a real stamp of local history and personality, but it will always be based on that improved dialogue. Put differently, improved dialogue locally, especially - but not only - between professionals, has to be a pre-cursor of integration, not an afterthought. It may well be that from this process local champions emerge.


\(^{19}\) [http://www.scotland.gov.uk/Topics/Health/Policy/2020-Vision](http://www.scotland.gov.uk/Topics/Health/Policy/2020-Vision)
These preparations will not just happen. Partnerships - or existing parent bodies - will want to consider putting in place transition managers whose energy is focussed on making sure partnerships and localities hit the ground running.

Effective integration will take many years. It will be important to focus on the medium term, to manage expectations and to persevere. But locality work needs to be built organically and to an extent opportunistically. Localities should think creatively about possible early wins. Success breeds success.

From our conversations, one front runner could be a step change in the availability of home care and intermediate care. Whilst this might not be straightforward to deliver, it would have an immediate beneficial impact. Others would be integrated support for physical activity linked to the 2014 Legacy work; greater use of link workers between general practice and the community; changes to the deployment of NHS community staff, in particular health visitors and mental health workers, responding not only to HEAT targets but also to the emergence of localities; or a refreshed dialogue with secondary care around the availability of expertise in the community. Early wins may even include stopping things: e.g. a realisation amongst hard pressed, frazzled professionals that they are wasting much less time at meetings whose value is greatly diminished by the absence of either people or data from a key sector. Above all, this is about starting small with things which are achievable and valuable in the local context. There will be a long queue of those who want to blame all future ills on integration: we need to be as quick to articulate the very tangible ways in which it will bring benefits.

Next Steps

It is tempting to allow ourselves the luxury of time, on the basis that the deadlines relate to 2015 and we do not need to rush. However, a lesson from Highland is that, however long we take in preparation, many of the issues will only be resolved once we get cracking. Moreover it will be important that there is a locality mindset from day one, not as an afterthought. There is therefore a strong case for setting deadlines which are not unreasonable but give impetus to the project. In that sense I recommend that we are clear that all partnerships need to have their locality arrangements up and running by April 2015. In broad terms that would mean:

- Local events- September- January 2013
- First draft of guidance available – February 2014;
- Locality boundaries agreed – March 2014;
- Statutory guidance issued – July 2014
- Shadow locality arrangements established – July 2014
- Locality input into strategic commissioning plans - September 2014;
- Locality arrangements up and running - April 2015

I hope that these thoughts will help prepare the way. The next stage will focus very much on local discussions but if anyone wishes to react to/comment on this report they should feel free to email Max Brown (Max.Brown@scotland.gsi.gov.uk) or Alex Devoy (Alex.devoy@scotland.gsi.gov.uk). There are several more areas which could be covered (e.g. commissioning models, role of the trade unions, implications of Self Directed Support etc.), but time has
allowed me neither to tackle them nor, as they say, to make this report shorter. It is now time to hand the baton over to where it belongs - to the partnerships and others who ultimately will take the ship safely to its destination.

Frank Strang FRCGP (hon)
Deputy Director
Scottish Government
July 2013
Stakeholders consulted

In preparing this report I, and my colleagues Max Brown and Alex Devoy, have had discussions with a range of SG colleagues and, amongst others, representatives of the following:

- West Lothian CHCP
- NHS Borders/Scottish Borders Council
- Social Work Department, Dundee City
- East Renfrewshire CHCP
- Perth and Kinross CHCP
- NHS Grampian
- Scottish Care
- The Health and Social Care Alliance
- NHS Primary Care Leads
- Royal College of General Practitioners
- British Medical Association
- Royal College of Nurses
- Coalition of Carers in Scotland
- Mental Health Services
- Allied Health Professionals
- The Association of Directors of Social Workers
- COSLA
- Joint Improvement Team
- The Directors of Public Health
- Chief Social Work Adviser
- Deputy Chief Medical Officer
- Martin Wilson, Consultant Geriatrician, NHS Highland
- NHS Greater Glasgow and Clyde
- NHS Board Integration Leads
- Nairn General Practice
- The Bill Advisory Group
- The Delivery Group for Health and Community Care
- Joint Strategic Commissioning – National Steering Group

I am grateful to all of these, and others, for their constructive input.
Annex B

**Locality Arrangements: principles**

**Draft principles agreed with stakeholders, 2012**

During a number of workshops held with stakeholders in 2012 the following draft principles emerged:

1. They are co-produced with local communities, users of services and their unpaid carers.
2. They are an integral part of their Health and Social Care Partnership and will be held to account for the delivery of local priorities.
3. They are based on trust and parity of respect between all partners.
4. They are multidisciplinary and multi-sector.
5. They have common purpose through an agreed scope and local outcomes for the population.
6. There is a clear understanding of the measurable outcomes for both services and service users, that will be delivered by multi-disciplinary teams.
7. They have a level of devolved financial and operational responsibility within the Health and Social Care Partnership to make decisions on the use of resources and service delivery for their communities.
8. They make a central contribution to the development and delivery of the joint strategic commissioning plans.
9. They will have a focus on creating health and tackling inequalities through service planning, co-production, support for self-management and asset based approaches.
10. They embody non-competitive direct engagement in the commissioning of support and services.

**Public Bodies etc Bill: overarching principles for integration planning and delivery**

The purpose is to integrate services which improve the wellbeing of recipients, in the way which, —

(i) is integrated from the point of view of recipients,
(ii) takes account of the particular needs of different recipients,
(iii) takes account of the particular needs of recipients in different parts of the area in which the service is being provided,
(iv) is planned and led locally in a way which is engaged with the community and local professionals,
(v) best anticipates needs and prevents them arising, and
(vi) makes the best use of the available facilities, people and other resources.
National health and wellbeing outcomes

The definitive wording of the national outcomes will be refined over the summer but in broad terms we are aiming to deliver the following:

1. **Healthier living**
   *Individuals and communities are able and motivated to look after and improve their health and wellbeing, resulting in more people living in good health for longer, with reduced health inequalities.*

2. **Independent living**
   *People with disabilities, long term conditions or who become frail are able to live as safely and independently as possible in the community, and have control over their care and support.*

3. **Positive experiences and outcomes**
   *People have positive experiences of health, social care and support services, which help to maintain or improve their quality of life.*

4. **Carers are supported**
   *People who provide unpaid care to others are supported and able to maintain their own health and wellbeing and have a life outside of caring.*

5. **Services are safe**
   *People using health, social care and support services are safe-guarded from harm and have their dignity and human rights respected.*

6. **Engaged workforce**
   *People who work in health and social care services are positive about their role and supported to improve the care and treatment they provide.*

7. **Effective resource use**
   *The most effective use is made of resources across health and social care services, avoiding waste and unnecessary variation.*