



# Integrating Health and Social Care in Scotland: Potential impact on children's services

## Report Two: Study Findings

A study commissioned by Social Work Scotland and undertaken by the Centre for Excellence for Looked after Children (CELCCIS) and Children in Scotland (CiS)

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The research team was very impressed by the professionalism, drive and commitment at all levels in both areas to make these changes work to the benefit of communities, families and individuals of all ages. In particular, we noted real determination to continue to provide high-quality support to the most vulnerable families and children, despite the increasing financial pressures both on service providers and families themselves.

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# INTRODUCTION

1. Over recent decades there has been a sustained policy trend across the UK and elsewhere promoting various forms of collaborative working for health and social care.<sup>1</sup> A number of drivers underpin these policies, typically focusing on meeting growing demand<sup>2</sup>, reducing costs<sup>1</sup> and improving effectiveness<sup>3</sup>. Policy and practice strategies to address these areas have included inter-professional working, joint assessments, structural alignment, co-location and sharing of budgets.
2. Evaluation findings to date have been somewhat mixed. Whilst many studies have identified improved outcomes, others have found these to be small or statistically non-significant; similarly whilst some studies have shown overall cost savings others have presented a more complex picture.<sup>1</sup> Other research has focused on identifying barriers to collaborative working and the factors which promote optimal conditions for integration.
3. This policy trend has been equally apparent in Scotland through a consistent movement toward greater integration. In 2010 the Scottish Government published the Healthcare Quality Strategy for Scotland.<sup>4</sup> This wide-ranging strategy lays out a need for *whole-system integration and alignment, an increased focus on preventative and anticipatory care, public sector partnerships and improved partnership working with social care*.
4. Subsequently, in May 2012, the Scottish Government began a series of consultative activities to explore perspectives and views on a proposal to integrate health and social care services for adults in Scotland. The resulting Public Bodies (Joint Working) (Scotland) Bill<sup>5</sup> was introduced to Parliament in May 2013 and received royal assent in April 2014.<sup>6</sup>
5. Whilst the Act's main focus was on the integration of adult services, the consultations identified a number of perspectives in relation to the effects on children and families. Therefore, in its 2011 position paper, Social Work Scotland (SWS; at the time the Association of Directors of Social Work, ADSW) drew attention to the need to be mindful of the potential impact of integration of adult health and social care on children's services:

*We must be careful not to treat health and social care integration as something that can be fixed in isolation. Undoubtedly there will be impacts on children's services, criminal justice social work as well as the health service. Success in one area cannot be at the expense or to the detriment of other areas.<sup>7</sup>*

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<sup>1</sup> Cameron, A., Lart, R., Bostock, L. & Coomber, C. (2013). Factors that promote and hinder joint and integrated working between health and social care services: A review of research literature. *Health and Social Care in the Community (in press)*

<sup>2</sup> Rummery K. (2009). Healthy partnerships, healthy citizens? An international review of partnerships in health and social care and patient/user outcomes. *Social Science & Medicine* 69, 1797–1804.

<sup>3</sup> Goodwin N., Smith J., Davies A. et al. (2011). A Report to the Department of Health and the NHS Future Forum. London: The King's Fund.

<sup>4</sup> For Healthcare Quality Strategy see <http://www.scotland.gov.uk/Resource/0039/00398674.pdf>

<sup>5</sup> For Bill documentation see <http://www.scottish.parliament.uk/parliamentarybusiness/Bills/63845.aspx>

<sup>6</sup> For Public Bodies Act see <http://www.legislation.gov.uk/asp/2014/9/contents/enacted>

<sup>7</sup> For ADSW position paper see [www.adsw.org.uk/doc\\_get.aspx?DocID=496](http://www.adsw.org.uk/doc_get.aspx?DocID=496)

6. This study was subsequently commissioned by SWS to explore the potential implications for children's services of the forthcoming integration of adult health and social care in Scotland through the new legislation, the Public Bodies (Joint Working)(Scotland) Act 2014.
7. Through this research, SWS wished to increase understanding of the potential issues for children's services resulting from health and social care integration. This includes identifying how areas are beginning to plan and deliver integrated health and social care services and how the planning process is addressing the impact on children's services and wider family services and supports.
8. In particular, the study aimed to answer the following questions:
  - What are foreseen as the likely implications for children and families of the integration of adult health and social care in Scotland?
  - What are perceived as the systems and service advantages and disadvantages of integrating health and social care for children in Scotland?
  - What types of integration of children's health and social care services are being considered in local areas?
  - What difficulties and barriers to integration are foreseen and what structures and processes are localities planning to respond to these?
  - What would be the characteristics of local areas showing successfully integrated children's health and social care services?

And, within two case study areas:

- What strategic, planning and change management processes have been put in place for health and social care integration?
- What processes have been followed to identify and address any potential detrimental impact of integration on children and families and their services and supports?

## CONTEXT

### Legislation and policy

9. The research was carried out at a time of very significant legislative and policy development led by the Scottish Government and the Scottish Parliament. We summarise these developments here since they provide context for the landscape in which the study was carried out.
10. The legislation to integrate adult health and social care, under the Public Bodies (Joint Working) (Scotland) Act was designed to address issues around delayed hospital discharge, bed blocking and disconnections within the NHS through the formation of new partnerships to improve joint working between, primarily, local government (who have statutory responsibilities for social care) and the NHS. The explanatory material stated that the legislation was aimed at strengthening community-based services so that more care can be provided in homes and communities to ease pressures on NHS acute and A&E services, and to make more effective and efficient use of resources, particularly in respect of supporting older people.
11. In terms of children's services, another comprehensive piece of legislation, the Children and Young People (Scotland) Act was also proceeding through its Parliamentary stages. This legislation was aimed at improving integrated and personalised support for children and young people through strengthening children's rights, placing in statute the key elements of Getting It Right for Every Child,

including the Named Person for every child, new requirements for joint planning of children's services, expanded early learning and childcare and improved support for looked after children. At the time of undertaking fieldwork for this study, new legislation was also planned to strengthen Community Empowerment.

12. The Scottish Government confirmed to the Scottish Parliament that it is permissible for local partners to integrate some, all or no children's services within the new Health and Social Care Partnerships created under the new legislation. This appears to provide local partnerships with significant flexibility to develop local structures and services for children and young people tailored to local circumstances and requirements. This flexibility contrasts with what we perceive as prescriptive and tightly-drawn legislative requirements for adult services in the primary health and social care legislation and the supporting draft regulations.
13. At the same time, local authorities and their partners were delivering major changes required by legislation on Self-Directed Support, the Review of Community Justice and a wide range of new strategies and policy initiatives intended to shift focus and resources towards prevention and early intervention from the earliest years of a child's life, including the work of the Early Years Collaborative.
14. Taken alone, any one of these major legislative developments would be regarded as substantial. Taken collectively, we consider that they represent major shifts in social policy and service delivery and it will be a significant challenge for those charged with leading, communicating and implementing the changes to do so in a cohesive way. We discuss this in more detail later in the report.

## Resources

15. Another contextual factor worthy of highlighting here is that of resource availability and allocation. Again, we discuss this aspect in more detail later in the report. In particular, we note that changes brought about by adult health and social care legislation, children's services legislation and the other legislative and policy changes are being implemented during times of unprecedented pressures on public funds.
16. Recent indications from national and local governments and from the NHS suggest that these financial pressures are only likely to intensify in the years ahead and that services previously regarded as sacrosanct may need to take a share of current and future cuts.
17. We note later in the report that there are many positive factors flowing from the health and social care legislative and policy changes and discuss some practical suggestions on how some of the problem areas might be addressed. However, it is important that these are seen against the wider financial context which one of our interviewees described as a 'perfect storm' of financial pressures on service providers and those most in need of support.

## Literature review

18. To complement the data-gathering arm of the study, a literature review was undertaken to glean further insights into the integration of health and care services. This review has already been published and the report is available on the CELCIS and Children in Scotland websites; key points of learning are summarised below. The review looked at academic peer-reviewed articles, policy and practice reports, legislation and guidance, as well as current legislative and policy drivers around integration, eg the Christie Commission recommendations and consultations in respect of the Public Bodies (Joint Working) (Scotland) Bill.

19. The literature review found that despite the lack of a clearly defined meaning of 'integration', political imperatives for improved integration have been driving policy and practice for several years in response to changing demographics, the desire to improve services and outcomes, and a need for greater efficiency and cost savings.
20. We also found that, to improve outcomes for service users, service integration beyond health and social care could be beneficial, especially for those who require a wide range of supports, eg the integration of housing, benefits, education, or transport.
21. The review noted that integration can occur at different levels within and across organisations, but that integration at locality level is crucial if policy objectives are to be met. To deliver success at locality level, revised organisational and financial structures are often required at other levels too. Practical actions, such as pooled budgets, co-location of services, inter-professional training and shared IT systems, need to be underpinned at all levels by strong and positive leadership, good communications and trust if successful integration of services is to be achieved.
22. The literature review concluded that challenges to successful integration include lack of individual and collective leadership, lack of common understanding and language within and across service providers, lack of clarity and communication, embedded professional differences, poor sharing of information and unwillingness or inability to pool or align financial budgets.
23. Literature sources also highlighted the important links between children and young people and adult services. Examples of areas where collaborative working between children's and adult services was particularly crucial included:
  - a) young people, including disabled young people, making transitions from children and young people's services to adult services where there may be wide-ranging, complex and diverse needs which require continued multi-agency support. There is a risk that, unless there are robust systems and communications between children and young people's services and those supporting adults, some young people will simply 'drop off the radar' and fail to receive the help they may well need;
  - b) identifying and meeting the needs of young carers who are supporting adults in their families;
  - c) care leavers who, unless they receive ongoing support to meet a potentially wide range of challenges (eg health, social care, employability, housing, etc) may experience poor outcomes; and,
  - d) vulnerable children who are in the care of adult service users. Some of these children may be at increased risk of neglect or abuse as a consequence of problems faced by parents or carers. Providers of adult services can be crucial in identifying and protecting these children through joint working with child protection and other children's services.
24. The literature review therefore concluded that the integration of adult health and social care services is likely to impact on various groups of children and young people and that their needs must be factored into decisions on service provision for adults. On the evidence of the literature review, we conclude that there are very significant implications for children and young people and the services that support them from the integration of adult health and social care in Scotland.
25. We also conclude from the literature review that the major legislative and policy changes being put in place by the Scottish Government present an opportunity for improving outcomes for adults, children and young people in Scotland, provided that the needs of children and young people are not overlooked, that they are given equal priority (including in respect of resources) and that links between children's and adult services at crucial transition points are reinforced, rather than weakened through the changes being put in place.

## STUDY METHODS

26. The study comprised three strands which were designed to gather the views of a broad range of stakeholders, and therefore generate understanding of multiple perspectives of health and social care integration. The three strands were: a national survey of senior managers and officials who had or were likely to have considerable input to the integration of services, case studies of two local areas, and interviews and focus groups with service users.

### National survey

27. The national survey aimed to gather the perspectives of senior members of staff from a range of organisations and sectors that were sufficiently broad to ensure research findings which were representative of the situation across Scotland.
28. The survey was administered through the secure online service Qualtrics and primarily used open questions to explore topics such as processes and planning around integration, what integrated services might look like, and the potential impact of integration on children's services. In addition, survey participants were asked to indicate whether they wished to be contacted by email to provide additional good practice examples. Alternative versions of the survey (eg Word or telephone surveys) were made available on request.
29. The survey was emailed to 279 'key informants' / organisations including local authority education and social work departments, health services, community planning partnerships and third sector organisations across Scotland, with the exception of two authorities which were involved in the research as case studies (see below). The survey was highlighted in various settings to try to promote response. Of the potential participants, 26 (9%) chose to take part in the survey. Whilst this is clearly disappointing, these participants provided rich and considered information which is of value to the study.
30. Of the seven local areas that indicated they would be willing to provide good practice information, two completed a follow-up survey with details of successful working practices in relation to integration.
31. These particularly low response rates may be attributable to the fact that the health and social care legislation was still passing through its Parliamentary stages and few local areas had a detailed idea of how they were going to proceed. Thus the survey was undertaken at a time when many potential respondents may have felt unable to provide useful information. However, the survey has provided valuable data about awareness in local government, the NHS and third sector, and about the positive and negative factors that either encouraged or concerned participants. These issues are discussed in the Findings section of this report.
32. It was evident that almost all responses came from participants who were in areas that had started planning change processes, but that work in several areas was at a relatively early stage.

### Case studies: two locality areas

33. We aimed to identify two localities where some progress towards integrating health and social care had been made and to invite them to become case study areas. After discussion with Social Work Scotland and with Directors in the local authorities, Inverclyde and East Ayrshire agreed to become case study areas.



34. In these localities, a broad range of participants from local authorities were involved, along with some representation from health services and the third sector. Participants were selected to ensure that potential contacts were those who were aware of the health and social care integration agenda and would be able to comment on process and potential impact. Research activity included groups (eg third sector meetings) and semi-structured interviews with individuals, and each participant's experience of the health and social care integration process guided the questions asked. Detailed notes of meetings and discussions were taken, and these were emailed to and agreed by each participant to ensure that we had reflected their views accurately.
35. What we hoped to glean from the two local areas were issues, both positive and negative, which local managers had encountered, and approaches to addressing these in order to identify lessons for wider consideration. These issues are discussed in detail in the Findings section of this report.

## Young person and family interviews

36. Although it was the intention of the research to involve a number of children and families within and outwith the case study areas, this proved particularly challenging. This was partly due to logistics, some sensitivities around access to vulnerable children and families and the potential limitations of service users' awareness of the new legal and policy environments and implications for services they use, particularly given the early stages of the new arrangements. We did not secure the involvement of any children or young people within the research.
37. We were very grateful, however, to be able to run a focus group of parents with learning difficulties who had experience of using a variety of social and health services, both for themselves and their children. The purpose of the focus group, which was held outwith our two case study areas, was to concentrate on identifying concerns and opportunities for service improvement through health and social care integration.
38. The question of 'need' was addressed by considering the extent to which services meet need rather than by a detailed examination of individuals' personal needs. Detailed notes of the focus group were taken by two researchers and sent to the group to review for accuracy. Our findings from this part of the study are also summarised later in the report.

## Consent and ethics

39. Consent to take part in all aspects of the study was premised on the provision of information about the study and how data would be handled and used. Consent to participation was obtained freely from participants, and taking part was seen as contingent upon participants' ongoing willingness to be part of the study.
40. We were keen to seek open and frank views from all participants in the study and anonymity was guaranteed to individuals who participated. For this reason, no views in this report are attributed to any individuals.
41. The research and proposed methodology was given ethical approval by the University of Strathclyde's Ethics Committee and all elements of the study were undertaken in line with the relevant principles of ethical research.
42. A thematic approach to analysing the information was taken with at least two researchers being involved with the analysis to promote robust and unbiased interpretation. Core analysis concentrated

on identifying organisational and systemic features which were likely to have an impact on the integration of health and social care services and the provision of services to children and families.

## FINDINGS

43. Findings of the research are reported below in thematic form, bringing together information gained through the different research methods in order to identify distinctions and similarities.
44. The findings are presented in subsections, for example exploring the different approaches to integration, high-level issues that have arisen (including opportunities, challenges and risks), approaches used to drive integration forward, and users' experiences of public sector services and how these may be addressed by the new processes.
45. As mentioned earlier, the study was undertaken while the primary legislation was proceeding through the Scottish Parliament and before draft secondary legislation was issued for consultation. In these circumstances, it was unsurprising that the levels of knowledge and understanding that the researchers encountered varied considerably across professions, grades and geographical areas.

## Approaches to integration

46. It was noted by participants in both case study areas that local partners had already made significant progress in: integrating planning, service design and delivery, pooling and aligning budgets, merging management structures (eg NHS staff being managed by local authority staff and vice versa) and introducing locality planning and services (eg co-located services and 'hub' models) based on community participation and prioritisation, prior to the introduction of the Act. The new legislative requirements were not, therefore, regarded as starting from a blank piece of paper.
47. It was noted by several interviewees that any improved outcomes in the short- to medium-term are likely to be attributable to pre-existing policies and initiatives, rather than being solely the result of improvements arising from new legislative and policy requirements.
48. The case study areas have adopted slightly different approaches to implementation of the new health and social care legislation. Inverclyde's Community Health and Social Care Partnership incorporates children's and family health and social work services and criminal justice social work. Educational Services remain within Council control, but they are involved as partners in the inclusive 'Nurturing Inverclyde' approach via community planning structures. Inverclyde interviewees saw this approach as building logically on existing partnerships and structures while minimising disruption, fragmentation and possible confusion, both to service users and service providers.
49. In East Ayrshire, Children and Families and Criminal Justice Social Work Services have been included within the Health and Social Care Partnership, with the Council retaining responsibility for Educational Services. This preserves the unity of Social Work Services in East Ayrshire. Arrangements are in place to ensure the continuity of the strong links that exist across Educational and Children and Families Social Work Services, resulting from the previous structure in which Educational and Social Work Services were constituent partners of the Department of Educational and Social Services.
50. A collaborative approach is also being adopted for several health services which will operate across the whole of Ayrshire. These services will be managed by individual Health and Social Care Partnerships but in agreement with the other Ayrshire partnerships. Risk and option appraisals have

been used to help decision-making on optimum allocation and placement of services within new partnership structures.

51. These arrangements have provided a valuable opportunity to compare potential approaches to integration and this has been very helpful in shaping this report.
52. The extent to which children's services were included in integration partnerships varied across local areas responding to the survey. A number of areas indicated that there would be full integration of services. It is not clear to what extent this is beyond social work services, for example, whether it includes criminal justice and / or education. In at least one area 'full integration' did include education services.
53. In local areas where children's services were being partially integrated, included services were typically community services such as health visiting, school nursing services, services for children looked after at home, and mental health services. In some areas, criminal justice services have also been included.
54. It was noted by NHS participants in the survey that they may have additional complications dealing with multiple approaches to integration across the different local authority areas they cover, including, as some noted, dealing with some authorities who wished to integrate children's services and others that did not. As in the case study areas, there was some evidence of the introduction of shared services across neighbouring authorities.
55. Several participants indicated that the local areas they were in would not be integrating children's services, and one area was undecided at the time of the study. In some areas, we were told that the decision to exclude children's services from the partnership would be subject to review, with the possibility that children's services would be integrated in the future. One participant commented that staff in children's services had been involved in discussions and noted that they would like to *remain outwith HSCI at this time*.
56. A notable point is that some areas viewed the integration process as a means to bring adult services up to the same level of quality of provision as children's services:

*Children and young people's services throughout NHS [Board] already have robust integrated, multi-agency planning arrangements in each of the local authority areas which will continue to develop and mature. This state has evolved over a number of years supported by national scrutiny models. Children's services are therefore not a priority to be included in the formal integration models and our local authority partners are in agreement with this. (senior NHS representative)*

## High-level issues

57. There was a great deal of consistency in the key issues being considered by local areas in their move towards integration; these emerged from our interviews in both case study areas, and from senior leaders' and managers' responses to the survey.
58. The issues that were identified by participants were broad and variously viewed as 'Opportunities, Challenges or Risks' to current management structures and modes of service delivery. Issues could be classed in more than one category depending on the perceived impact and current functioning of services:

## Opportunities

### *Strengthening partnerships*

59. Most of our senior interviewees in case study areas saw the new legislative changes as an opportunity to build on existing partnership working, since the changes provide a stronger legal 'scaffolding' and could help to compel any reluctant partners to strengthen engagement with others. The more formal and prescribed structures in the legislation were also thought to provide clarity, consistency and leverage for the future to reinforce roles and responsibilities and to accelerate progress.
60. Within the survey, a number of participants indicated that the delivery of mental health services and psychological therapies would particularly benefit from improved partnerships.
61. Conversely, in one area where only adult services were being included in the Health and Social Care Partnership, one survey participant expressed concern that measures should be put in place to ensure that mental health services did not become further disaggregated and more difficult for children and families to access as Child and Adolescent Mental Health Services (CAMHS) and adult mental health were typically delivered together, not in children's services.

### *Financial integration*

62. It was evident from our interviews that a great deal of progress has already been made in areas such as integration of services and sharing of human and financial resources. However, implementation of the new legislation was seen as an opportunity to make further progress, for example, improving relationships within and across local partnerships, more sharing of data and information at both strategic and operational levels, breaking down professional barriers and, crucially, improving outcomes for service users in the longer term.
63. An example of potential opportunity came from an NHS Director who noted that a disproportionate share of local NHS resources are consumed by a small proportion of the population. This participant suspected that a similar percentage of local authority expenditure would be directed towards the same communities and families, but was unsure. They concluded that new legislation would lead to more sharing, pooling and analysis of data and information which would result in better targeting of services and financial resources, and that more joint working around information and data would also help to identify gaps which could be resolved with partners.
64. Additional findings from the survey suggested that shared financial resources would make transitions smoother and improve access to services. Disabled children were highlighted as a group who might benefit from integration because the *finances follow the child* and not the service. Sixty-one percent of survey participants (14 of 23) agreed or strongly agreed that transitions from children's to adult services would improve for disabled children following integration; four participants (17%) disagreed and five (22%) neither agreed nor disagreed.

### *Consultation and engagement*

65. Another positive observation noted by case study participants was that the new legislation on adult health and social care and the Children and Young People Act both include provisions to strengthen local consultation, participation and engagement with local communities, families, children and young people. We were told that a great deal of excellent work is already ongoing in both case study areas, but it was felt by several interviewees that more could be done and that the legislation will provide a valuable impetus.

66. In another local area identified through the survey, plans to extend and enhance engagement included a public consultation on the area’s integration plans.

### Shared structures

67. Survey participants indicated that shared service structures were a positive feature of integration, improving access to services for different user groups, notably disabled children and other children. Particular benefits highlighted by several senior health and local authority survey participants included streamlining of services, such as, *improved speed of response from initial concern to assessment*, better communication and exchange of information, and better access to equipment and care packages (as opposed to the more common situation where different partners offer distinct aspects of the care service).
68. It was noted by one participant that this would provide a better experience for families who would need to engage with only one management structure, and attend fewer meetings.

### Service improvement

69. It was evident from the case study areas and survey findings that a number of local areas were using the Act as an opportunity to overhaul current service delivery systems, whether this was through expansion, streamlining or other general improvement.
70. For example, some areas planned to introduce services to typically *hard to reach* or *hidden* groups of service users including young carers, fathers, and looked after children, although improving access to mental health services was highlighted as a problem by a number of survey participants.
71. Figure 1 below, however, suggests that less than half of survey respondents are confident that there will be better services following integration. This appears to be primarily linked to a feeling that services are already working well rather than any suggestion that services will be made worse by integration:

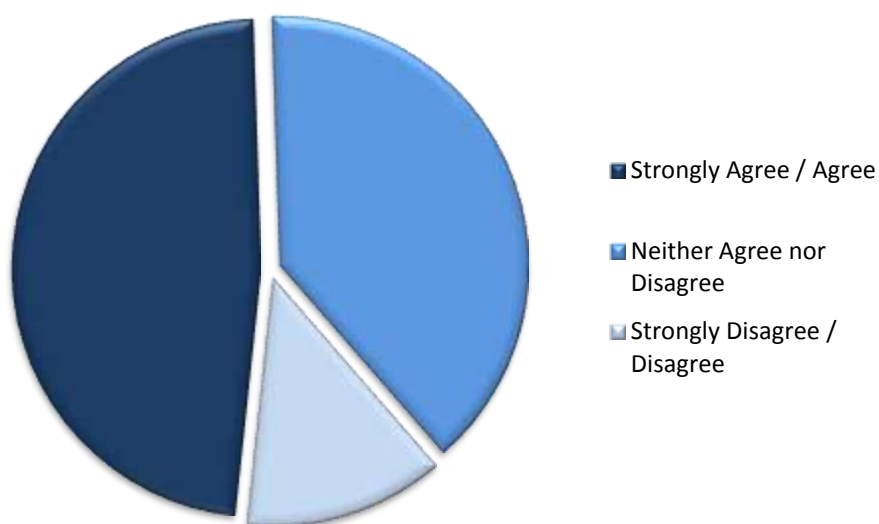


Figure 1: Our area will provide better services to children, young people and families after integration

## Planning

72. A number of survey participants identified benefits arising from the introduction of new planning arrangements. At service level, benefits specified included allowing services to plan to meet needs so children and young people experience long-lasting improvements, more effective and timely provision, extended help and support at an early stage for children, young people and families, and improved interface between children's and adult services, which included clearer and faster referral routes.
73. At a strategic level, survey participants noted that opportunities which could arise from new planning arrangements included more effective strategic commissioning, improved effectiveness of quality assurance and self-evaluation, and clearer lines of accountability and decision-making processes. This would mean that approaches such as locality planning, asset-based planning and co-production of services would become increasingly mainstream.

## Challenges

### Policy and legislative contexts

74. Concerns about the complexity of the new legal and policy environments were cited by most of our interviewees and survey participants. As indicated earlier in the report, local leaders, managers and providers have to simultaneously implement a raft of *game-changing* legislation and policy. In particular, *the impact of integration cannot be seen in isolation from work to implement the Children and Young People (Scotland) Act 2014 and broader GIRFEC [Getting it right for every child] planning* (NHS participant).
75. This presents major challenges, for example, in terms of articulation and communication of complex plans, leading culture change, redesigning structures and services, use of staff time at all levels, and management of human and financial resources whilst also maintaining the delivery of high-quality services to current users.
76. In addition to new legislation and policy, participants also mentioned existing frameworks that they had to observe which added to the complexity, including *Early Years Framework, Achieving Our Potential, Curriculum for Excellence, We Can and Must do Better, and self-directed support frameworks* (NHS participant).
77. Several participants noted that these structures and frameworks already promote an integrated approach to working, which would occur via implementation of these approaches, and *despite the integration legislation* (local authority participant).

### Planning and bureaucracy

78. In the same vein, most of our locality area interviewees were concerned about the complexity and bureaucracy around new and existing planning requirements, eg ensuring fit, clarity, consistency and coherence. Both the Health and Social Care and Children and Young People legislation impose new or revised planning requirements on local partners. These specifications come on top of existing requirements such as Community Plans, Single Outcome Agreements and a host of other required local authority and NHS plans.
79. We noted many concerns about the amount of time at all levels within and across partnership organisations required to prepare new plans and ensure adequate levels of internal and external consultation and engagement, while at the same time leading and delivering structural and service redesign. For example, NHS Boards may cover several separate local authority areas and will have to

work with their local authority partners on multiple new health and social care schemes and plans, as well as new children's services plans.

80. To address these planning issues, Inverclyde partners have designed a 'virtual' planning IT platform which is intended to pull together all the cross-partnership planning requirements into an integrated model, whilst East Ayrshire have designated a senior officer to coordinate the wide variety of plans required for the area to ensure consistency and coherence.
81. The health and social care legislation requires new strategic plans to include specifications for at least two separate localities. We noted concerns that existing locality and community-based planning and service delivery might be jeopardised if over-rigid interpretations of locality planning are taken by the Scottish Government when scrutinising new health and social care strategic plans.
82. There were calls for the Scottish Government to articulate how existing and new planning requirements fit together and to review planning requirements across the board to look for scope to rationalise and streamline what is perceived as an increasing burden on local managers and staff.

### *Community led planning and partner engagement*

83. In the course of our interviews, we learned of many examples (eg Vibrant Communities in East Ayrshire) of community led locality planning which involves local communities in decision-making and building community capacity and assets. Linking those locality plans with new and existing strategic plans was seen as a challenge, as was ensuring an appropriate and coherent balance of 'bottom-up' and 'top-down' planning.
84. Participants provided mixed views about what seems to be variable levels of engagement in locality planning and service delivery by GP practices. It was acknowledged that GPs are independent contractors but there was general recognition of the important role they could play by becoming more engaged with locality-based services (eg community service 'hubs').
85. A survey participant further explained that:

*A critical NHS provision for children is through GPs who have strong relationships which will develop further [but] ... expecting GPs to have similarly strong relationships with separate social work children's services is problematic (senior NHS representative).*

86. We interviewed several groups and individuals representing the third sector in both case study areas. There was a general consensus that levels of participation, engagement and consultation with statutory partners had improved substantially in recent years. There was also a shared view that more could be done to strengthen engagement and this was recognised by relevant local authority officers who have links with the third sector.
87. Some representatives felt that the third sector still is not regarded as a key strategic partner nor involved in high-level planning and decision-making. However, it was acknowledged that it remained difficult to identify the most appropriate local third sector representatives to invite to join strategic and other committees, given the scale and scope of the services provided by the sector and given that local voluntary organisations are often in competition with one another for funding.

### *Performance management and monitoring*

88. Complexity and bureaucracy in respect of existing and new performance management and monitoring was also mentioned as a potentially expensive diversion of management and staff time. One of the

performance coordinators we interviewed estimated that they were already aware of over 400 measures and indicators that had to be recorded and reported for a combination of local and national monitoring.

89. Concerns were also highlighted in relation to the complexity of different approaches to outcomes measurement in different areas or services within partnerships. It was felt that some of these focus on management structures rather than health or care outcomes. A senior health representative stated that there was a potential for this to lead to greater inequality across services due to *different priorities and delivery systems* (senior NHS representative).
90. This complexity may be further exacerbated by the inclusion of a new set of national outcomes in the new health and social care legislation (ie different from those in the existing National Performance Framework) and that the Children and Young People Act includes new indicators of children's wellbeing based on the SHANARRI principles.
91. There were suggestions that the Scottish Government and local partnerships should consider the scope for rationalising and simplifying performance management and measuring across individual organisations and wider partnerships.

### *Integrated service delivery*

92. There were concerns that the exclusion of education services from the health and social care legislation may weaken or undo current positive structural arrangements between health and education, which were considered by some to be the *main integration partner for health services* (NHS participant).

### *Finance and resource allocation*

93. As indicated earlier in the report, there are UK-wide and Scottish resource and financial factors which, we consider, are likely to have an adverse effect on the delivery of the legal and policy intentions set out by the Scottish Government. However, the research team were provided with many examples of budget pooling and budget alignment and examples of flexibility already in place at locality levels.
94. Despite the progress they felt had been made, several of our interviewees thought that more needs to be done to clarify financial governance and accountability, in order to break down financial and professional silos and barriers, allowing greater flexibility for effective resource allocation and value for money, while still retaining clear lines of accountability and robust audit trails.

## **Risks**

### *Public sector funding*

95. Funding from the Scottish Government to support the costs of implementation and transitions were warmly welcomed by many of our interviewees. However, this welcome was more than outweighed by serious concerns about services' ability to cope with the increasing demand to deliver high-quality services for adults, children and families. For example, one senior manager faced with major budget cuts saw the future as short-term crisis care for only the highest tariff individuals and families, leaving others to third sector providers or their own devices until such time as they reached crisis point.
96. It was also evident from interviewees in both case study areas that those who plan and deliver services for adults are working in environments where older people are living longer but are presenting with increasingly complex needs which are labour- and resource-intensive for providers. While the legislative and policy intentions to provide more community-based services for the elderly



are laudable, there is no 'year zero' in that a significant and, perhaps, increasing number of older people will still require hospital-based interventions. Aspirations for wholesale transfer of acute and other NHS budgets to community-based services will, therefore, need to be realistic.

97. The majority of our interviewees agreed wholeheartedly with the principle of shifting resources from 'damage limitation' to prevention and early intervention. Indeed, we heard about many examples of local services where these principles are already being applied.
98. However, we also heard concerns (reflected in several recent national research reports) that welfare cuts, sanctions and rising living costs are likely to swell the numbers of children and families living in severe poverty and that this is already affecting quality of life, health and wellbeing, as well as creating increasing demand and pressures on local services. We also noted concerns that health and other inequalities (including levels of alcohol and drug use, and mental health issues) are increasing among our poorest and most vulnerable families and communities, and that services are struggling to cope.
99. These accounts suggest that adults, children and young people already in receipt of packages of care, which are often intensive and expensive (eg at the 'damage limitation' end of the spectrum) are likely to continue to require support in future and that there is a risk that their numbers will increase as further pressures on families and providers are imposed.
100. Our view is that these factors make the scope for large-scale resource transfer to prevention, early intervention and early years support challenging to deliver. Those in national government, other political parties and the media may need to be realistic about what can be achieved against this backdrop of intense pressures on providers and the most vulnerable service users.

#### *Finance and Resource Allocation*

101. In our national survey and in some of the case study interviews, there were worries that the education sector might be sidelined and given lower priority for resources unless fully integrated into the new Health and Social Care Partnerships. Some participants concluded that this scenario could jeopardise the successful delivery of the statutory Named Person function under GIRFEC and have an adverse effect on child protection.
102. Some interviewees and survey participants envisaged greater competition for increasingly scarce resources between those managing services for older people and those managing services for children and young people, with the likelihood (rightly or wrongly) that children's services could lose out, given the political imperative of the adult health and social care agenda.

#### *Finance and the Third Sector*

103. We noted concerns that negotiations between local authorities, NHS Boards and other statutory partners on implementing new legislation and policy, and particularly negotiations around financial resources, risk pushing the third sector further towards what one interviewee referred to as 'the end of the food chain'.
104. Given the increasing pressures on resources in the statutory sector, several third sector interviewees were worried that their own funding could be at serious risk. This was placed in the context of a time when their services are struggling to cope with increasing caseloads of challenging and complex needs presented by families and individuals, many of whom are referred to them by statutory partners who, in turn, have increasingly serious funding and capacity issues.

### *Fragmentation of Services*

105. Another risk factor we noted from several interviewees concerned possible fragmentation of services which could jeopardise the 'holistic' family-based approach advocated under GIRFEC, increase risks to children in households where parents or carers are supported by adult services (eg drugs or alcohol) and which could increase the risk of children and young people 'falling off the radar' at crucial transition points in their lives.
106. Survey findings indicated that fragmentation of services may be particularly problematic in local areas where children's services were not being included in the Health and Social Care Partnership. There were serious concerns about divisions that may be caused within services currently working together, including, for example, divisions between adult and children's social work services.
107. Some of our interviewees added that areas where children's and adult services were managed and funded by different partnerships or organisations could face increased risk of fragmentation and losing children and young people from contact with services. This could have serious implications, for example, for child protection and for those children and young people within and leaving the care system.

### *Professional Relationships*

108. We record professional relationships under the 'risk' category, even though they are also a powerful positive driver for success. In both our case study areas, participants told us that strong and long-term professional relationships had been built over time among many senior directors and managers. We were told that these relationships had helped significantly in providing leadership, trust, confidence and problem-solving capacity within and across key partnerships in local government and the NHS in particular. These relationships have, for example, helped smooth the way for joint management arrangements, despite some inevitable tensions in respect of terms and conditions.
109. The need for strong and positive professional relationships at all levels, but particularly at senior levels, is noted later in this report as one of our key drivers for success. It may seem perverse, therefore, to include this item as a risk. The reason for doing so is to signal the potential benefits of having alternative strategies to take forward the raft of new legislative and other obligations, in addition to reliance on personal relationships.
110. Our concern is that staff at the heart of these relationships may move to other posts or retire early which could potentially leave a vacuum affecting services at strategic and operational levels. While we applaud the very positive and powerful relationships which have built up and their undoubted benefits, it is necessary to consider processes for succession and contingency planning to avoid any disruption to leadership or delivery.

### *Evidencing Progress*

111. We highlighted earlier the wider financial and social factors that, we believe, will affect both the timescales and extent of successful delivery of new legal and policy priorities. Given that both case study areas have significant levels of poverty and deprivation, it is certainly worth considering the concerns from a wide range of interviewees that they face an uphill struggle to deliver progress against increasingly severe pressures on budgets.
112. Several senior interviewees concluded that it might take several years to embed these changes. Even then, it might be difficult to determine which improvements had come about from national and local policies and activities which pre-dated new legislation and policies, and those that had been generated from the more recent changes.

113. There were also some fears that the major structural, organisational and financial changes being implemented would take so long to bed in and to show tangible evidence of delivering their objectives, that the Scottish Government might react to any political and media criticism by ‘shifting the goalposts’ with even more legislation and policy. It was suggested that this could only exacerbate the challenges being faced by local partners. There were strong calls from all levels of interviewees for sufficient time to be allowed to implement the changes and to make them work.

### Accountability

114. A political leader and several senior staff noted that the health and social care legislation and supporting (draft) regulations are tightly drawn and prescriptive, giving Scottish Ministers a range of powers to approve or reject schemes and to intervene in what some perceived as local democratic decisions. It was suggested that this combination of prescription from the centre, NHS accountability to Scottish Ministers and local government accountability to local electors could lead to tensions and friction in future.

115. Participants contrasted the prescriptiveness of the health and social care legislation with the apparent flexibility that local leaders and planners have to integrate all, some or no children’s services within Health and Social Care Partnerships. Some interviewees felt that this would result in a very wide variety of adult and children’s service models across Scotland despite the fact that it seems the Scottish Government is looking for greater consistency.

116. Participants often expressed a hope that the Scottish Government will take a flexible and realistic approach when assessing and approving new health and social care schemes and plans, and that they acknowledge that local partners are best placed to identify local needs and priorities and to design and deliver services and budgets to meet these needs.

### Concluding remarks

117. We have highlighted scenarios about opportunities, challenges and risks that are being faced by local areas during the process of integration of health and social care services. Mixed views are held about these opportunities and risks by different individuals and services within any given area, and it is likely that there will be some losses and gains in each area, eg fragmentation and splitting of some teams, but at the same time opportunities for new developments and partnerships.

118. Furthermore, it is worth noting that a number of survey participants hoped that health and social care implementation would have no impact on service delivery and that the public would see *little difference due to organisational changes* (local authority participant). For some participants no impact for service users was anticipated because it was felt that health and social care services were already aligned, integrated and working well.

119. In the chart below (Figure 2) it will be seen that nine participants (39%) disagreed or strongly disagreed that there would be negative consequences for children and young people’s services. A further 39% of participants were uncertain (neither agreeing nor disagreeing) that there would be negative consequences or were certain that there would be negative consequences (22% of participants). This underlines the perceived complexity of implementing the legislation and ensuring that potentially negative effects are addressed.

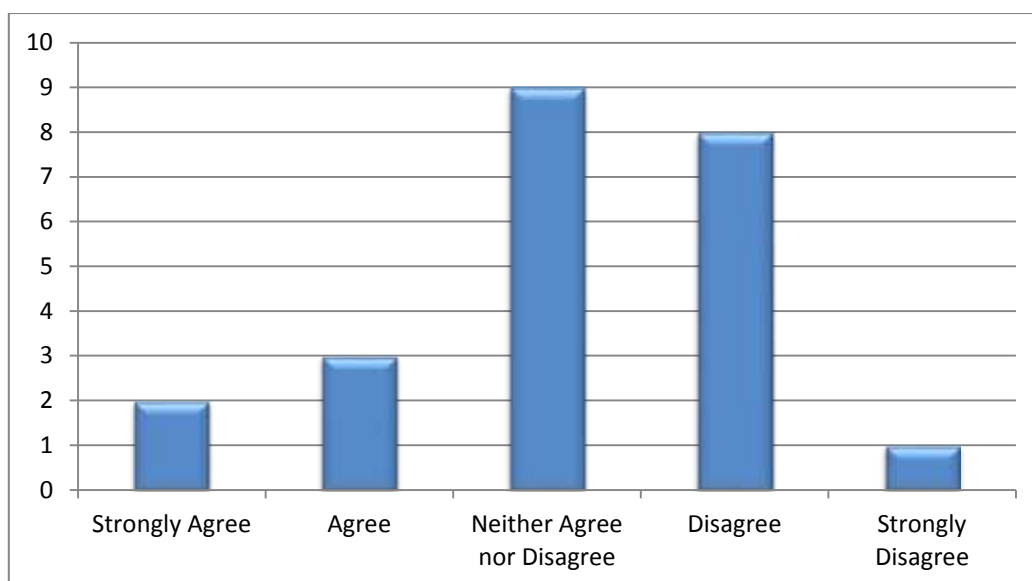


Figure 2: Changes are likely to have negative effects for some groups of children, young people and families

## Key drivers and actions for success

### Introduction

120. In this section of the report, we seek to summarise the key actions being taken by leaders to achieve success in implementation. It is interesting to note the clear correlation between the drivers and actions identified in the interviews and survey findings and those factors for success referred to in the literature review.

### Strong and positive leadership within and across partner organisations

121. Leaders, directors and senior managers in both of our case study areas were well aware that the scale and complexity of changes to be implemented would require strong, positive and coordinated leadership. They recognised that part of their role was to break down professional and financial boundaries within and across agencies and to provide clarity, reassurance, common priorities and shared understanding.

122. It was notable that many of our interviewees stressed the importance of strong personal and professional relationships within and across agencies. Indeed, this factor was cited by several individuals as the most important driver of success, rather than legal and policy prescriptions from the centre. One leader summed this up: *It will be people who will make these changes work, not structures or bureaucracy.*

123. There was agreement that if leaders and senior managers show individual and joint commitment to working together to articulate and drive forward changes generated by new legislation and policy, this will provide the confidence and reassurance to other staff, particularly front line workers, to work more closely together. This should then contribute to improved services and outcomes based on the needs of individuals of all ages, families and communities.

124. Local leaders and senior managers were also determined to make cultural and professional change a reality by taking seriously and addressing any issues raised by staff, regardless of their professions or

grades. We were told that this openness and willingness to get involved had helped to resolve some sensitive staffing matters (eg around terms and conditions) that arose during integration.

## Planning

125. As highlighted earlier, planning was a key feature of implementation of the new legislation and one on which local areas spent a significant amount of time. Different partners were involved in the process across local areas. The table below provides details of some of the different groups and services included in planning. Not all services would have been involved in all areas:

**Table 1: Partners involved in planning (by sector)**

Local Authority Services	NHS Services	Other Services
Criminal Justice	Health Improvement	Third sector
Children and Families	Primary and Secondary Health Services	Independent care sector
Adult Social Care	Acute Services	Partnership Forums
Social Work Services	Mental Health Services: Acute mental health, Community mental health, Psychological services, Educational psychologists	Public representatives, including patients
Care Assessment Teams	Allied Health Professions (acute and primary care)	Trade Unions
Older People's Services	Care of the Elderly (in-patient units)	Police Scotland
Physical Disability Services	Day Services	Having Your Say Forum (Looked After Children)
Education, including Teachers	Occupational Therapy	
Financial services	Nursing Services: Community Nurses, District Nurses, Looked After Children's Nurses	
Elected Members	Health Visiting Services	
Social Policy Services	Dental services	
Strategic Planning Services	Public Health & Health Policy	
Directors of CHCPs	Financial Services	
Employee Relations	Strategic Planning Services	
	Directors of CHCPs	
	Employee Relations	

126. Thirteen (56% of 23) survey participants either agreed or strongly agreed that all of the appropriate partners had been involved in the planning process. Seven (30%) disagreed that the appropriate partners had been involved. Three participants neither agreed nor disagreed.

127. It is somewhat concerning that around a third of participants in this sample believe that planners fail to invite input from all the relevant partners. If this is reflected more widely, it may suggest that opportunities to inform new structures and service developments are potentially being missed.

### Prioritising children’s services

128. Although everyone we interviewed was acutely aware of the increasing pressures on resources, leaders were already endeavouring to reassure staff and the wider public that supporting children and young people in their areas would remain one of their highest priorities and would not have a lower priority than adult services. The need to ensure that children’s services retained priority was also a key issue identified by survey participants.

129. Survey findings showed mixed views about whether sufficient consideration had been given to the impact of integration on children’s services. Ten participants (43%) agreed that there had been sufficient consideration but eight (35%) disagreed. This might suggest that less attention or visibility may have been given in some areas to ensuring children’s services receive equal priority to adult services, this is shown in Figure 3:

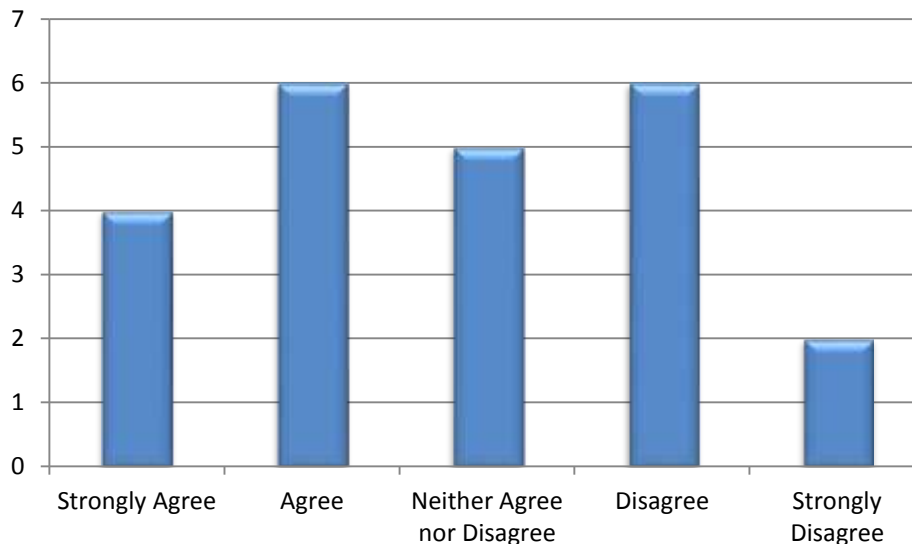


Figure 3: The impact of integration on children's services has been given sufficient consideration

### Communicating changes to staff

130. Leaders in both case study areas were acutely aware of the need to carefully articulate strategic changes, including implementation plans for revised priorities, resourcing and staffing. These needed to be shared from top management levels to front line providers. They accepted that the scale and complexity of change requires clear, accessible and understandable communications to ensure that all staff within and across organisations are aware of what is happening, where they fit into new structures and how these are going to work at regional and locality levels.

131. Against a backdrop of severe financial pressures, which could generate redundancies, it is not surprising that we found anxieties about the future. Also, it is understandable that staff who have had, or will have, their personal terms and conditions amended or management arrangements changed may feel particularly insecure about future employment and career prospects. Clear, frequent and

honest communications were regarded as being essential to address such anxieties and to reduce the risk of myths taking root and spreading on the basis of erroneous information or rumour.

132. The research team noted the East Ayrshire 'Stop Press' newsletter which is designed to communicate decisions, current thinking and ideas in an inclusive way. Local staff forums in both areas, as well as the 'open door' approaches taken by senior managers are clearly very useful to discuss changes and to obtain staff inputs.
133. Evidence from the survey suggested that other local areas were undertaking similar exercises to communicate changes to staff, including consultation exercises and staff meetings. One area, taking a broader approach, was developing a suite of educational resources about integration that could be shared across public sector organisations, and the independent and third sectors.

### **Data collection and information sharing**

134. It was encouraging to note how many of our interviewees see the changes being implemented as an opportunity to improve the gathering and sharing of information and data at both strategic and operational levels. This was seen as an important factor in improving communications, building stronger partnerships, improving knowledge and targeting services and resources more effectively. The roll-out of GIRFEC was also cited as a positive factor in encouraging greater sharing of appropriate information and data about children, young people and families to help improve outcomes.
135. However, several of our interviewees commented on the need for significant investment in improved and shared IT systems within and across partner organisations if aspirations for improved communications and data/information sharing are to work in practice.

### **Generating culture and practice change through building common priorities, understanding, language and training**

136. Several interviewees and survey participants from both local government and the NHS commented that they still felt that they operate to different priorities, different lines of accountability and performance management, and use different language and terminology. These factors were regarded as problematic as they led to tensions, confusion and overlap and acted as barriers to successful delivery of national and local integration priorities.
137. More positively, work to build on existing partnership arrangements generated through the new legislation and the spread of jointly managed posts and teams (ie mixes of local authority and NHS staff) were seen as key elements for addressing these concerns. There were also suggestions for more joint training and cross-agency professional development which, if done well, could help to break down barriers and improve awareness and understanding.
138. It was further noted that the introduction of qualifying training at SVQ Levels 7 and 8 for new and existing staff would be helpful to support workers in health, education and social care. It was envisaged that this would enable staff to share experiences of cross-agency working.

### **Reducing bureaucracy and complexity**

139. Bureaucracy was a common concern in both case study areas, and we covered the key issues in the 'Risks' section earlier in the report. Several of our interviewees felt that there may have been insufficient discussions at government level among Ministers and official Bill teams to ensure coherence between the requirements of the Public Bodies (Joint Working) legislation, the Children and Young People Act, Self-Directed support, Community Empowerment and reform of community justice.

140. Several senior interviewees felt that this had left local leaders, managers and planners with a host of new planning requirements on top of existing commitments. There were also concerns that multiple new performance measurement and monitoring requirements would flow from these new requirements, adding further bureaucratic burdens and taking up valuable time at all levels. It was felt that such time would be better spent driving forward improved service design and delivery in line with the policy aspirations that underpin the new legislation and policy.
141. There was determination and commitment to translate new national priorities into practical improvements at local level, but one senior manager commented that these improvements would probably come about despite the new legislation, rather than because of it.

## **Improved support for transitions and links between services**

142. We refer to these aspects earlier in the report, but believe that they are of sufficient importance to merit further comment in this section.
143. We noted strong support for the 'holistic' family-based approach which forms part of the principles guiding delivery of GIRFEC, and clear acknowledgement that local authorities' role as corporate parents places responsibilities on them to ensure that young people continue to get the help they need while in and when leaving the care system. There was also clear understanding of the importance of the education sector and the potential of schools as community 'hubs'. While significant progress had been made in these key areas, there was general acceptance that more could be done and that further improvements must remain a high priority.
144. However, we also noted concerns that the new legislative and policy environments might in some cases work against the development of these priorities, especially if children's and adult services are managed, funded and delivered by different local structures and partnerships who have different priorities which may be pulling in different directions.
145. Those leaders who we interviewed also recognised fully the serious challenges around resources and key pressure points such as links between adult and children's services, transitions, support for those in care and leaving care and child protection.
146. Again, these concerns contrast with the levels of understanding and commitment conveyed by leaders and senior managers who also cited the strength of personal and professional relationships as a defence against fragmentation of integrated family-centred support. We suggest that additional strategies to support implementation are likely to be helpful at times when there may be staff moves, retirements or redundancies.

## **Participation and engagement with families and communities**

147. As noted earlier, we were made aware of a wide range of approaches already in progress to improve engagement with those individuals, families and communities who use services. Our interviewees admitted that, inevitably, more could be done but stated that engagement, consultation and participation concepts are already embedded in local policy and practice.
148. It was also evident that local policy makers and practitioners had grasped the concept of building community assets and capacity to make better use of local skills and knowledge and help communities identify and prioritise issues and solutions to meet locality needs.
149. Given these local factors, new legislative requirements for consultation and engagement in both the Health and Social Care legislation and the Children and Young People legislation did not appear to



have created serious worries in either case study area. What we did hear, however, was that new requirements to consult and engage will take time to plan and deliver properly and that this must be borne in mind when setting local and national timescales.

## The role of the third sector

150. Interviewees from the third sector in both case study areas said that they had become more engaged with statutory partners and felt that their role had become better understood and more valued. Several of them noted, however, that they still felt they are not regarded as equal partners in the planning and design of local services and that they sometimes pick up the 'crumbs' by way of funding.
151. They also highlighted the point that the third sector delivers support for some very challenging and complex individuals and families who are referred to them by the statutory sector or who self-refer, perhaps due to mistrust of or unhappy previous dealings with statutory services.
152. There were understandable concerns about future funding, but also a realisation that the third sector could not be immune from the wider pressures facing public finances. We were asked to record, however, that larger and more complex caseloads are placing increased stress on third sector organisations, their staff, their funds and their capacity. Statutory partners need to temper expectations accordingly.

## Availability and allocation of resources

153. On the basis of what is said throughout the report, it will come as no surprise that this issue is regarded as being pivotal to the success or failure of implementing new legislative requirements and to the timescales for doing so. This was, by far, the most frequently expressed area of concern at all levels in both case study areas and was frequently mentioned in the survey.
154. The provision of transitional funding from the Scottish Government was very welcome and there were several pleas for its continuation in 2015-16 and beyond to enable local restructuring and service redesign to continue. Given the increasing pressures on local authority and NHS core budgets, financing continued transitions generated by new legislation and policy from these sources was not regarded as feasible.
155. As we note earlier in the report, there was strong support for the principles of moving resources from hospital-based services into community-led services and for shifting resources into prevention and intervention, starting in the early years of a child's life. For the reasons set out earlier, we encountered severe doubts about the practicalities of doing so, ie the possible creation of potentially dangerous shortfalls and gaps for those older people, adults, children and young people who will continue to rely on acute and intensive interventions, particularly in crisis situations.
156. Several of our most senior interviewees argued the need for long-term 'bridging finance', perhaps spanning a generation, to allow time for the priorities of prevention, early intervention and improved early years support to work and to reduce demand for acute and intensive services. This suggestion was made in the knowledge of wider financial pressures and competing priorities at national and local levels.
157. The argument was, therefore, couched in terms of the Scottish Government needing to consider its spending priorities across the board and reflect on whether their laudable and well-supported legislative priorities could be delivered without further injection of significant long-term funding.

## Service users' perspectives: parents with learning disabilities

158. A group of five parents with learning difficulties agreed to take part in a focus group (NB this was outwith the case study areas) to tell us about their experiences of using services, and the support they received for themselves and their children. Early on in the focus group it was clear that parents were disillusioned and frustrated with the services and support they received. One participant described accessing services as being like constantly facing 'slamming doors', ie a door to support may open only to be quickly closed or a service denied because of increasingly high thresholds.
159. The findings presented in Box 1 below explain parents' experiences of services at the frontline, and describe the many difficulties they encountered when trying to access a suitable and integrated service for their family:

### Box 1: Service user perspectives: parents with learning difficulties

Parents started off by telling us they were unhappy with the support they received from social workers. They felt there was not enough support for adults with learning difficulties, particularly parents, and that generally social workers do not have enough practice of working with parents with learning difficulties.

Throughout the focus group it became evident that participants felt services fell short of meeting their needs in a number of critical ways which are outlined below:

#### **Professionals do not listen**

Focus group participants told us that they often asked services for support and highlighted difficulties they were having at home. However, they were frustrated because professionals from many services including social work and education, did not listen to them or offer support until the family reached a crisis. Similarly, local councillors who parents approached for support were not perceived to be very helpful, and parents felt the councillors had not properly understood the issues they were raising.

#### **Lack of early intervention / Prevention**

Lack of support at an early stage led to families requiring intervention in times of crisis. Participants stated that when their family reached crisis point this would sometimes be classed as neglect by services even though they had already asked for help.

We were told by participants that this was counterproductive and did not make financial sense, costing the council more money in the long term to provide crisis interventions than ongoing support.

#### **Insufficient support**

It was parents' experience that some authorities and services defined any provision of more than three hours a week as intensive support, which the group felt was not enough for many parents.

#### **Lack of continued support**

Parents' comments suggested that much of the support they received was short-term and time-bound. They noted that children's services were not able to provide as much ongoing support as adult services, although adult services did not offer support for long enough either.

**Lack of consistent support**

As well as support not being kept in place long enough, other problems were caused by a lack of consistent support. One member of the group had found that the support they and their child had received at primary school was much better than that received at secondary school.

**Lack of appropriate timing of support**

When support was provided, it has not always been given at a good time or place for parents or children. For example, support workers came round after children had gone to school when the parents would have liked help with the children, perhaps before school or in the evening.

**Lack or delayed provision of information**

Sometimes parents had not received information that they had sought, for example, from health visitors.

Similarly parents told us schools often provided information much later than requested, sometimes after a school trip or event had passed, or they did not provide information at all. This could limit parents' knowledge of and participation in their children's education.

Having failed to be provided with requested information, parents also felt that they had not been informed about entitlements, such as self-directed support. They felt that they were not provided with information about self-directed support or other entitlements because professionals thought parents with learning difficulties would not be able to read any of the information needed or write an application.

**Lack of integrated support**

Participants and their families often used both adult and children's services for support but found that the two did not necessarily work well together. The two services also worked differently which some participants found confusing. Examples we were told about included professionals not being allowed to help with tasks outside their specific role, eg support workers or health visitors have not always been permitted to help read letters from the school as they say it is not part of their job. In other instances participants told us about some health services not being able to remind parents about appointments for their children.

**Lack of Scottish Government awareness of service quality**

Some members of the focus group suggested that there was a lack of awareness at senior levels, including the Scottish Government, about the poor quality of services. The group felt that this was because local authorities only ever talked about services that were working well. The government did not therefore get to hear about what is not working well.

**Participants made some suggestions about improving services:**

- Support should be more flexible, available when parents need it, and provided by someone who is known and trusted.
- Good practice training for professionals should be introduced. A number of the group told us that they had met with members of the Council to talk about introducing training on the good practice guidelines.
- Parents would like to meet with councillors and decision-makers who decide what money is spent on services.

- Finances should be spent on early intervention services to stop families getting into crisis. This would mean less money will need to be spent on crisis support.

160. Many of the issues raised by parents are noted by local authorities and health boards as being addressed in the implementation process, for example, continued support, greater support, integrated support and improved consultation and engagement.
161. Parents and professionals were equally concerned about early intervention. Parents felt the focus of service provision is currently on crisis support with insufficient early intervention, whilst participants in local areas were concerned that the provision of early intervention support was under threat as a result of cutbacks.
162. There were other areas of concern which had not been raised by professionals but which were highlighted by parents. These included quality issues such as professionals not listening to service users' requests for help, lack of appropriate timing of support and not being provided with information about services, including education. This suggests that a critical component of service improvement should be to involve all kinds of service users in order to inform any changes to service delivery.
163. Finally, we note that parents who took part in the focus group were individuals who sought support; they were not difficult-to-reach populations and they wanted to do the best for their families. This raises a number of issues around thresholds, eligibility for support, assessment and referral which need to be clarified during the implementation process and service developments.

## CONCLUSIONS

164. The research team sincerely hopes that this report and the preceding literature review fulfils our remit from Social Work Scotland. We hope, too, that those leaders, senior managers, officers, planners and front line staff in the statutory and third sectors in our case study areas will feel that the report reflects the wide range of extremely useful and insightful contributions they made to this study.
165. The study was carried out at a relatively early stage in the implementation of new health and social care and children's services legislation. We are also aware that a range of statutory and other guidance is currently in preparation.
166. Some key elements of change and articulation of change, therefore, have still to be put in place and communicated to managers and staff. Thus, it is not surprising that the research team received such a wide variety of positive and negative comments, some of which were clearly associated with uncertainty about the future. We believe, however, that there are some firm conclusions and suggestions we can offer to Social Work Scotland.
167. We are clear from the study and the preceding literature review that the integration of adult health and social care services affects children and young people, as service users and potential users of adult services, and as members of families who use adult services. For these reasons, services for adults and children cannot be planned, funded and delivered in isolation from one another.
168. We also conclude that having adult and children's services managed and funded by different local structures does carry potential risks. This conclusion needs to be qualified by stressing again that leaders and senior managers in both case study areas are clearly aware of this. Risks include:

- Services not being able to take a ‘whole family’ approach to assess need and to deliver integrated packages of care;
  - Children not being adequately protected (eg in households where there is domestic abuse, substance misuse etc.);
  - The creation or persistence of gaps at crucial transition points in a child’s life (eg shifting from children’s to adult services, leaving care, etc.).
169. Timescales: While we fully understand the need to show progress and results, we have considerable sympathies for those participants who anticipate that it will take considerable time to ‘bed in’ the new structures and services, and that it may take 10-15 years before the major changes being implemented show improved outcomes on a significant scale.
170. Resources: We also support the view from many participants that intensifying resource constraints are likely to have an adverse effect on the speed and scale of progress at local levels and this factor, as well as timescales, needs to be borne in mind when success, or otherwise, of new legislation and policy is judged.
171. We, therefore, understand the rationale for suggesting continuation of transitional funding, and that generational ‘bridging funding’ may be necessary. This would allow the shift towards community-based services, prevention and early intervention to happen by reducing demand at the acute and intensive ends of the service spectrum without leaving gaps in hospital-based support for the elderly and intensive packages of care for children, young people and families. Whether this is feasible in the current financial environment is questionable. We record these observations for further discussion.
172. We were encouraged by the progress made in both case study areas with regard to issues such as jointly managed posts, co-located multi-agency services, and pooled and aligned budgets (some of which had been devolved to locality levels).
173. We appreciate the need for financial accountability and governance of public funds. However, we suggest that more effective and efficient use of scarce resources could be made if the Scottish Government and local partners work together to explore the potential for relaxing some financial controls to help provide greater flexibility to underpin local multi-agency and integrated services, particularly at locality level.
174. Information sharing and IT support: The value of improving the gathering and sharing of data and information within and across organisations and partnerships was evident, from strategic planning and budgeting through to improving outcomes for families, adults, young people and children. We agree that the implementation of GIRFEC should act as a further catalyst to take these priorities forward. However, we noted concerns about the lack of compatible IT systems within and across agencies and acknowledge that this could be a significant barrier to progress. We were reassured that analysis of IT needs is happening within the case study areas, but perhaps a national review is needed to look at costs, best practice, etc.
175. Planning and bureaucracy: These were the areas in which we heard strong and frequent concerns in terms of likely time commitment to fulfil current and new planning requirements and associated performance management and measurement. We support the view that there must be scope for rationalisation and simplification to ensure that maximum time is spent on making legislative and policy changes work for service users and front line providers, rather than on bureaucratic processes. This is an area which, we suggest, could benefit from a high-level review, potentially led by the Scottish Government with key partners.

176. We understand that Scottish Government officials are working on a wide range of new planning and guidance documents to support implementation of legislative provisions for health and social care and children's services, including GIRFEC. We suggest that this presents a valuable opportunity to take an overview of all current work on new guidance and other work that is being planned, to ensure coherence and address several of the key concerns set out in this report.
177. These suggestions are not founded simply on reducing bureaucracy. We are concerned that, if appropriate links are not made and acted upon at national and local levels, the problems we identify around interaction between adult/children's services, child protection, care leavers and transitions are more likely to occur with consequent damage to outcomes for children and young people. Some more detailed suggestions for those working on new planning guidance are set out in the attached annex. Social Work Scotland is, no doubt, involved in these processes and may wish to take these suggestions into account.
178. We hope that these suggestions and an outline of our key drivers for success are helpful to Social Work Scotland, to national and local government and to local partners in framing new guidance, local strategies and practices. The research team would be happy to discuss any aspects of these suggestions and the wider report if further information or clarification is required.

#### **Children in Scotland and CELCIS**

# ANNEX

## Suggestions for new planning guidance

There should be formal requirement on those preparing plans for adult health and social care and those preparing new Children's Services Plans to work together and to set out clearly in the plans how they will link adult and children's service planning, design, delivery and sharing of appropriate information to ensure that holistic, family-based approaches are embedded in service delivery, and to specify what arrangements are in place to ensure continuity of care at key transition points in children and young people's lives (particularly those in the care system or with complex needs).

We suggest also that Children's Services Plans should include narrative on the role of schools, both in terms of GIRFEC implementation (eg Named Person) and their potential to play wider roles within communities.

There should be formal requirement that Local Child Protection Committees and Local Alcohol and Drug Partnerships should be involved in the preparation of new Children's Services Plans and Adult Health and Social Care Plans, and it should be recorded in these plans that these organisations are content that the actions set out in the plans will contribute positively to improving child protection in the area.

New guidance could also set out Scottish Government expectations and parameters to address local concerns about flexibility in terms of existing area-wide and locality-based services.

This could help to ensure that the Scottish Government achieves its apparent aim of ensuring a degree of consistency across Scotland, while avoiding possible disruption to existing local and locality-based arrangements already in place with a proven track record of joint working and improving outcomes, particularly in more deprived and vulnerable communities.