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Health and Social Care integration: managing the change



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1. Introduction

In April 2016, arguably the biggest structural change the public sector in Scotland has seen in recent years will come fully into effect. From that date, in most parts of the country, new Integration Joint Boards will become responsible for a wide range of health and social care services presently provided by Councils and Health Boards. These Integration Joint Boards will be independent legal entities with full autonomy and capacity to act on their own behalf.

The Public Bodies (Joint Working) (Scotland) Act 2014 sets out the legislative framework for integrating health and social care. It sets down the functions which must be delegated by Councils and Health Boards to Integration Joint Boards, primarily services related to adults and older people. However, Councils and Health Boards may also choose to include other services, for example services covering the health and social care of children, where there is local agreement to do so. As a result, the public sector landscape of the future is likely to be less uniform than it is at present.

Although other structural reforms such as the merger of Colleges, or the creation of a single police service and single fire and rescue service, have already taken place, these changes were very much sector specific. The integration of health and social care services stretches across both the local government and health sectors but only covers some of their functions. As a result, the change is much bigger in both scale and complexity.

The purpose of this paper is not to examine the operational challenges associated with all structural reforms, such as making appointments, arranging accommodation, organising support services and planning for the integration of ICT systems, albeit they themselves represent a considerable challenge. Instead, this paper seeks to identify the key challenges associated with the integration of health and social care which, to a large extent, will determine the success or otherwise of the reforms.

2. Benefits of Integration

The main objective of the integration is to improve the wellbeing of the people who use health and social care services, particularly those whose needs are complex and involve support from both health and social care at the same time. The aim is to create a single system for the local joint commissioning of health and social care services, which is built around the needs of patients and service users, and which supports whole system redesign in favour of preventative and anticipatory care in communities.

The changes will also be expected to help manage the financial pressures which are anticipated over the next few years. A recent Fraser of Allander Economic Commentary / IPPI Occasional Paper “The Scottish NHS: meeting the financial challenge ahead”¹ considered a crisis of affordability in the next couple of decades as the population ages and demands on services intensify. The demand on local government services will be no less intense and, indeed, may even be more challenging as many of these services will be less protected from funding reductions than the health budget, which is seen as a priority by all the main political parties. So, the prize of integration is great – improved outcomes for services users, while at the same time meeting the pressures of increasing service demands, within a climate of reducing resources. But what are the key challenges which have to be overcome to achieve these goals?

3. Political landscape

The first key challenge lies in the timing of the changes, which legally come into effect just before the Scottish Parliament elections in May 2016. Their first full year of operation will end just before the local government elections in 2017 and, over this period, the UK Government’s austerity plans will be being deeply felt. While the extent to which this will impact on Scottish public service provision will not be clear until early to mid - 2016, most, if not all, public sector bodies are planning for very tight funding settlements.

This will undoubtedly be a period of heightened political tension where local decisions about service delivery will come under intense public scrutiny. Discussion on sensitive issues will be played out at meetings of the Integration Joint Boards, Councils, Health Boards and the Scottish Parliament. The competence of these bodies, in managing this reform, will be firmly in the spotlight. As a result, this will be a particularly testing time for all those involved – politicians, board members, professionals and front-line staff alike.

¹<http://strathprints.strath.ac.uk/50288/>

Recommendation 1: Given this political landscape, it will be vital that all those involved in the change to create integrated care build upon the wide political support that exists for the principle of integrated services and concentrate on being able to demonstrate improved *outcomes* for service users at the earliest possible date.

4. Governance

The second key challenge concerns the governance of the new Integration Joint Boards. There are two ways in which health and social care functions may be integrated. The first option is for the Council and the Health Board to delegate responsibility for planning and resourcing service provision to an Integration Joint Board. (A “body corporate” arrangement). This arrangement is being adopted in all but one of the 32 local authority areas. The second option is for the Council or the Health Board to take lead responsibility for planning, resourcing and delivering integrated health and social care services. This is the option being adopted in the Highland area where, broadly speaking, the Council will be responsible for all children’s services and the Health Board responsible for all adult services.

Under the “body corporate” arrangement a new separate legal entity, an Integration Joint Board, will be created, with full autonomy and capacity to act on its own behalf and, accordingly, will be able to make decisions about the exercise of its functions and responsibilities as it sees fit. It will be responsible for the strategic planning of the functions delegated to it and for ensuring the delivery of its functions through locally agreed operational arrangements.

The Integration Joint Board will be made up of voting and non-voting members. The voting membership will consist of an equal number of Councillors and Health Board members. Typically there will be 4 Councillors and 4 Health Board members, however, the actual numbers will vary across the country according to the size of the local population. In addition, there will be a number of non-voting advisory representatives, for example the Chief Officer and Chief Finance Officer of the Integration Joint Board, and the Chief Social Work Officer of the Council. Where a voting member is unable to attend a meeting, the Council or the Health Board may arrange for a substitute to attend. However, the substitute must be a member of the Council or the Health Board as the case may be.

Critical to the success of the integration arrangements will be the behaviour of the members of the Integration Joint Board, particularly the behaviour of the voting members nominated by the Council and the Health Board. It will be crucial that, at all times, these members act in the

interests of the partnership and not their host organisation. In other words, although the individuals will be nominated to the Integration Joint Board by either the Council or the Health Board, they are not there to *represent* these organisations. That is not to say they should not be mindful of the implications for the Council or the Health Board of their decisions, but rather their priority must be to act in the interests of the partnership. They will be there to be the champions of health and social care services in their area.

Recommendation 2: This co-sponsored (Local Authority / NHS) governance challenge is not unique to Health and Social Care but will, nevertheless, have to be carefully managed. Development programmes will need to be organised for all Board members, including substitutes, covering both the lead-in to April 2016 and the early period beyond. There is an opportunity for a national or regional approach to enable best practice to be shared. It would also be of benefit to Board members if national or regional support networks were established to allow practical experience to be shared.

5. Management Model

The third key challenge is the model of management of Health and Social Care staff. Under legislation, a Chief Officer must be appointed by the Integration Joint Board, albeit they will be employed by either the Council or the Health Board. The Chief Officer will have day to day operational responsibility for the monitoring of the delivery of services delegated to the Integration Joint Board by the Council and the Health Board.

At the same time, however, they will be jointly line managed by the Chief Executives of the Council and the Health Board, the same people who will have overall operational responsibility for the delivery of the majority of the services. The Chief Officer will lead the Partnership's Senior Management Team but will also be a member of the Senior Management Team of the Council and the Health Board. This is a complex arrangement with the clear potential for conflict. It will be important that it is recognised that the relationship between these three senior staff will be a delicate one, and one that will have to be carefully nurtured.

All other appointments, with the exception of the Chief Finance Officer, are discretionary. Crucially, however, all staff will remain employees of either the Council or the Health Board. This means that staff who will be working in joint teams will be on different terms and conditions of employment. In the case of issues such as annual leave, public holidays, flexible working

hours and sickness pay, experience has shown that staff are not unduly concerned by such differences. Issues such as basic pay and overtime arrangements, however, can be more contentious unless they are at the margins.

The two issues which will be most contentious, particularly within the context of significant service redesign, are the policies of “No compulsory redundancy” and “Lifetime protection of earnings”. With regard to the former, most Councils do not operate a formal policy of “no compulsory redundancy”. Instead, they tend to use the issue as a negotiating position indicating that compulsory redundancies will only be used as a last resort. In Health, there is a clear policy of “no compulsory redundancies”. As regards the latter, by and large, Councils operate a policy of “paying the going rate for the job” with little or no protection given to staff affected by service change. By contrast, In Health, there is a formal policy of “lifetime protection of earnings”.

Recommendation 3: In order to manage the differences in Local Authority and Health Board terms and conditions, and the inevitable displacement of staff arising from service redesign, there is a need for comparable Voluntary Redundancy Schemes to be developed for both Council and Health Service staff. In the absence of such comparable schemes, the differences in terms and conditions will very quickly become a serious barrier to change.

While the benefits of integrated working should be clear to the Senior Management Team of the Integration Joint Board, it cannot be assumed that they will be as clear to all other staff, particularly those who have no experience of working in joint teams. For example, if staff continue to be employed by the Council / Health Board where will their loyalties lie? For the vast majority of staff, their future career prospects will remain with the Council/Health Board. Issues such as absence management, matters of discipline and grievance, will continue to be managed in accordance with the procedures of their employer (the Council or the Health Board). And these procedures are likely to vary between the two organisations. For integrated working to succeed, great care will have to be taken to ensure it is not a case of “he who pays the piper calls the tune”.

Recommendation 4: In order to address the challenges of integrating care services it will be necessary for Councils and Health Boards to take a lead in promoting a culture where staff put the wellbeing of service users first, over and above the individual employer's interests (Council or Health). Workforce Development Plans will need to encourage, and reward, such behaviour and career progression criteria will need to include the willingness, and ability, of staff to embrace this model of working. Personal Development Plans will also need to assist staff in making this cultural change.

6. Service Redesign

The fourth key challenge will be the development and implementation of service redesign programmes. It is a requirement that Integration Joint Boards prepare Strategic Plans which set out the specific arrangements which will apply at locality level, for example plans to further shift the balance of care away from hospitals, and to introduce new models of care. These plans must also set out how those arrangements will contribute to the achievement of national health and wellbeing outcomes.

There are two broad drivers of change which will have to be carefully considered. The drive for improved outcomes through integration will be guided by issues such as the need to ensure that services are integrated from the point of view of service users, take account of the particular needs of different service users, and of the particular needs of service users in different parts of each local authority area. Ideally, this would be by far the most important driver of change. However, in the current financial environment, this will have to be balanced against the drive to meet financial efficiency and savings targets, and to meet increasing demands for services.

As far as possible, change that involves the integration of services should be driven by the desire for improved outcomes for service users, with any financial savings simply being a consequence of the change, and not the reason for the change. Conversely, where the change is finance driven then, ideally, it should not involve the integration of services. In practice, however, these lines are likely to become blurred.

Recommendation 5: For the integration agenda to be seen genuinely as being about improved outcomes for service users, then these two drivers of change – service user outcomes and financial savings / sustainability – will have to be clearly separated from one another. It will also be crucial that a medium to long-term view is taken in the design of future models of care, in order to address the financial challenges that will arise as the population ages and demands for services intensify.

These two broad drivers of change will put intense pressure on Integration Joint Boards, Councils and Health Boards. From a national viewpoint, the scale of change taking place is likely to be unprecedented, with different solutions for the same issue being developed in different parts of the country, or even within the same Health Board area, at the same time. Great care will have to be taken to ensure that change programmes are viewed by the public as being the result of “positive local choice” and not a “postcode lottery”.

Recommendation 6: In order to avoid the undue variation in services, consideration should be given to the use of a Centre of Excellence, to share knowledge, spread best practice and promote new models of care. This would also enable a national overview to be taken of the changes.

Financial Challenges

The fifth key challenge and, perhaps, the biggest challenge facing the new Integration Joint Boards will be managing the services against a background of a severe reduction in resources, coupled with growing cost pressures. Although it is too early to establish the level of savings the new Boards will need to achieve over the next year or two, there is little doubt it will be significant. It is likely to be early in the new year before an accurate picture begins to emerge, as Councils finalise their budgets before setting Council Tax levels. Historically, Health Boards have not finalised their budgets until early summer.

On the face of it, although this challenge will be the same for Councils and Health Boards, these organisations are long established with tried and tested methods of living within their means. The narrative surrounding the services provided by Councils is consistently about choice and priorities, with there being a general acceptance that there are insufficient resources to continue

to provide all services at their current level. The narrative in health is slightly different with the pressures of increasing service demands being partially masked by health spend being seen to be protected as a political priority and often addressed through in-year allocations of additional resources. The narrative for Health and Social Care, in its new environment, has still to be written.

As newly established bodies, the Integration Joint Boards will need to develop and implement their own Financial Assurance processes. The National Guidance, which has been issued by the Scottish Government, will be helpful in this regard. The importance of financial assurance has been recognised in legislation, with there being a requirement that Integration Joint Boards appoint a Chief Finance Officer, who will act as the Board's proper officer under Section 95 of the Local Government Act 1973. The Chief Finance Officer is one of only two officer appointments required by legislation, the other one being the Chief Officer.

An early challenge for the Integration Joint Board will be in seeking assurance that the resources it receives from the Council and the Health Board are sufficient to allow it to properly deliver the functions delegated to it. An exercise of due diligence will require to be carried out to make this assessment. Largely, this will be based on the current year's budget, together with previous years' actual expenditure and future years' forecasts.

It's no exaggeration to say that the success of the integration of Health and Social Care, at least in its infancy, will depend greatly on the robustness of this due diligence exercise, and the perceived fairness of the outcome of the budget negotiations for all parties.

Once the budget allocations have been agreed, the immediate challenge will then be the delivery of services to agreed performance standards, within approved budget limits. Although, as previously mentioned, Health Boards often receive additional resources in-year to meet growing or new service demands. The new Integration Joint Boards will be expected to live within their means from day one, with the same degree of rigour being applied to budgetary control as is presently applied by Councils and Health Boards. Arrangements will exist for the management of budget overspends and underspends. In the case of the former, this is likely to be managed by the Integration Joint Board receiving an additional budget allocation which will require to be repaid in future year(s). However, this is a situation to be avoided as it will only serve to create a bigger financial challenge in later years, and will have unwelcome short-term financial implications for the Council/Health Board. It is also likely to be seen as being a "failure of management" and will place a severe strain on relationships between partners at a time when they are still earning each other's trust. Conversely, any underspends will be retained by the Integration Joint Boards in the form of reserves.

Recommendation 7: With so much at stake, the Integration Joint Boards should consider placing a caveat on their initial budget allocations. This could be achieved by identifying the impact of non-recurring funding and one-off savings, and the risks associated with delivering on efficiency and savings targets. This would effectively lay down an audit trail for any request for supplementary funding if these risks materialise and could not be managed, at least in the short term.

7. Additional Issues

This paper has identified five key challenges associated with the integration of health and social care services— political, governance, management model(s), service redesign and financial – which, to a large extent, will determine the success or otherwise of the reforms. However, there are two further challenges which, although not so immediate, will nevertheless need to be addressed sooner rather than later.

First of all, attention will need to be given to the ongoing relationship between the Integration Joint Boards and other services within Councils and Health Boards. The integration of health and social care services will be judged a failure if it is only achieved at the expense of working relationships with other services. This is particularly the case with Education services, where increased political priority is now being given to closing the attainment gap between the highest and lowest performing pupils. It will also be important that staff in health and social care continue to fully participate in Community Planning and continue to develop close working relationships with Police and other protective services bodies, for example on Adult Protection issues.

Secondly, if the principle of integrated services is to become fully embedded in the minds of the public and staff, then further consideration will need to be given to the title “health and social care services”. This name only serves to emphasise that there are two services that need to be integrated. What is required is for there to be a shared vision – and language – of future models of care and for these models to be given a new name. A name which describes the services at the end of this journey of change and not one that is a constant reminder of the journey itself.

8. Conclusions

The integration of health and social care services is arguably the biggest structural change the public sector in Scotland has seen since the establishment of the Scottish Parliament in 1999. As a result of the timing, and the scale and complexity of the changes, the competence of the Scottish Government, Councils, and Health Boards, together with the new Integrated Joint Boards, will be firmly in the public and media spotlight.

The purpose of this paper is not to examine the operational challenges that can be associated with all structural changes, but rather to identify and discuss the key challenges facing health and social care partnerships over the next eighteen months or so. These challenges relate to the political landscape, governance, staff management, service redesign and financial management and, to a large extent, how they are addressed and implemented will determine the success or otherwise of these vital reforms.

Two further challenges have been identified: ongoing relationships with other services and the description of future models of care. These challenges, while not so immediate, will still require to be addressed, sooner rather than later.

This paper makes a number of recommendations to help to anticipate and overcome these challenges. It will be crucial to the success of these reforms that these recommendations are acted upon as a matter of priority by Local Authorities, Health Boards and the Scottish Government as well as by the new Integration Joint Boards – working together to focus on developing new practice, diffusing this widely across Scotland and ensuring sufficient investment in this to ensure the success of this vital service reform.

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