Voluntary Action Scotland

COALITION OF CARE AND SUPPORT PROVIDERS IN SCOTLAND

ALLIANCE
HEALTH AND SOCIAL CARE ALLIANCE SCOTLAND
people at the centre

Developing the Third Sector's Role in Health and Social Care Integration

A Note about this Handbook

The Scottish Government has recognised that it is important that the third sector is able to engage with the ongoing development of integrated health and social care, as reorganised due to the Public Bodies (Joint Working) (Scotland) Act 2014. It has provided support to the third sector for capacity-building, in order to enable the sector to achieve the following outcomes:

- Third sector organisations successfully find a route into the new health and social care structures.
- The third sector becomes an integral part of that new landscape.
- The third sector engages effectively when present, makes a difference, and facilitates change as a result.
- There is a raised profile for the third sector as a contributing partner, including capturing activity at a local level, with evidence to inform outcomes, thus making visible the assets of the whole system.

This handbook is a resource primarily intended for Third Sector Interfaces, but we hope it will also be of use to others engaged in shaping, defining or clarifying the role of the third sector locally.

Disclaimer

In developing this handbook we have drawn on multiple sources and have included what we believe will be of value. But, as with any resource of this nature, we have not been able to cover every relevant detail, so we have also included a number of outward links to resources, information and organisations that may be worth exploring further to inform the development of your work.

Underlined links in blue will take you on to the web to resources that might be useful.

Links in purple will take you to another part of this handbook where further information is available.

The handbook has been designed in a non-linear fashion so that you can dip in and out of it and use the parts that are of use to you – it is not intended to be read start to finish, like a book. There are additional tools and resources available in supporting documentation available for TSIs from Voluntary Action Scotland (VAS); these are distributed separately.

Terminology

This handbook uses the phrase **Integration Authority** or **Integration Authorities** throughout. An Integration Authority is the term used by the Scottish Government to reflect that integration schemes have two options – one establishes an *Integrated Joint Board,* and the other appoints a *Lead Agency* (either the NHS Health Board or local authority). In practice, only Highland has opted for the Lead Agency approach.

Glossary

The **Glossary of Terms** included in this handbook has been reproduced from the Scottish Government's *Health and Social Care Integration Communications Toolkit*.

Contents

A Note about this Handbook 2
Disclaimer 2
Terminology 2
Glossary 2
1. Introduction 6
1.1 The Handbook 6
1.2 Why Integration is Important 6
1.3 Work to Date 6
1.4 Background to Integration 7
1.5 The Principles of Integration 7
1.6 What Is Being Integrated? 8
1.7 Implications for the Third Sector 9
1.8 Connections across Community Planning 10
1.9 Catalyst for Change 11
2. Defining the Role of the Third Sector and the TSI 13
2.1 The Role of the Third Sector 14
2.1.1 Co-ordinating these Roles 15
2.2 Framing the TSI Role 15
2.3 Creating a Start Point 17
2.4 Partnership Brokering 17
2.4.1 Co-ordinating Diverse Voices 19
2.4.2 Connecting 19
2.4.3 Synthesising and Hosting Information 22
2.4.4 Communication and Presentation 24
2.4.5 Capacity-Building 24
2.4.6 Reviewing and Revising 25
Tool 1 – Identifying Partners and Relationships 27
Tool 2 – Assessing the Partnership 30
Tool 3 – Relationship and Influence 36
Tool 4 – Readiness Assessment 37
Tool 5 – Readiness Assessment – Version 2 40
3. Improving Strategic Commissioning 42
3.1 The Role of Strategic Commissioning in Integration 42
3.1.1 Strategic Planning Group 42

3.1.2 Measuring and Reporting How Plans Contribute to Better Outcomes 44
3.1.3 Scrutiny 44
3.2 Third Sector Health and Social Care Provider Issues 45
3.2.1 Procurement, Austerity and Funding Cuts 45
3.2.2 Level Playing Field 46
3.2.3 Impact on Service-Users 46
3.2.4 Multiple Interests and Roles 47
3.2.5 Relationships and Collaboration 47
3.3 What Strategic Commissioning Is 48
3.4 Relationship with Procurement 50
3.5 Barriers to Good Strategic Commissioning 51
3.6 Enabling Good Commissioning: Approaches and Tools 52
3.6.1 Alliance Contracting 52
3.6.2 Public Social Partnerships 53
3.6.3 Key Questions for Partnership Meetings 53
3.6.4 Tools to Support Working Together 54
3.7 Investing in Partnerships 55
4. Gathering and Using Data 56
4.1 Introduction 56
4.2 Challenges in Data Management 58
4.2.1 Who Does What? 58
4.2.2 Too Much Data 59
4.2.3 What Is Good Data? 59
4.2.4 National vs. Personal Outcomes 64
4.3 Useful Sources 64
4.3.1 The Integration and Intelligence Project 64
4.3.2 MILO 65
4.3.3 ALISS 65
4.3.4 Public Health Information for Scotland (ScotPHO)'s Online Profile Tools 65
4.3.5 Understanding Scottish Places (USP) 66
4.3.6 Other Sources 66
5. Health Inequalities and Prevention 69
5.1 Introduction 69
5.2 Health Inequalities 69
5.2.1 Understanding Health Inequalities 69

5.2.2 Addressing Health Inequalities 70
5.3 Prevention 72
5.3.1 Preventative Spending 72
5.3.2 Approaching Prevention 73
5.4 The Role of the TSI and the Wider Third Sector 82
6. Resourcing a Local Case 83
Glossary 86
Appendix A – Background to Integration 92
Overview of Health and Social Care Integration 92
The Legislation 93
Legislation Overview 93
Key Features of the Act 93
Regulations 94
National Health and Wellbeing Outcomes 95
Human-Rights-Based Approach 97

1. Introduction

This section provides an overview to the legislation and principles that underpin health and social care integration and their implications for the third sector.

1.1 The Handbook

Health and social care integration is a massive undertaking initiated by the Scottish Government to enhance the quality of health and social care services and to improve health and wellbeing outcomes for the Scottish population.

The third sector, and in particular Third Sector Interfaces (TSIs), have a key role to play in making integration a success. This handbook pulls together information from a wide range of sources to help TSIs make sense of what is happening, how the process is being structured, and how they can, with their partners, shape their future role.

To achieve this, we have included a set of questions and tools for TSIs to use to explore how they will approach their role in integration. Using these questions will assist the TSI in exploring:

- What is already being done?
- What needs to be done?
- What does the third sector believe it can contribute?
- What value can third sector involvement bring to health and social care integration?

Using the questions and tools included in this handbook will help the TSI to analyse the current position and determine future requirements – information that can then be used to build a case for local resourcing of the third sector contribution to integration.

1.2 Why Integration is Important

The integration of health and social care is intended to improve outcomes and quality for those who use health or social care services. Integration is about more than bringing together services from two organisations; it has broader aims: improving health inequalities, bringing about culture change, and making the delivery of care and support as efficient as possible. All of these are topics in which TSIs currently have an interest.

1.3 Work to Date

On 6 October 2014 a dialogue event was held by ALLIANCE, CCPS and VAS in Edinburgh. This was attended by around 40 people from the third sector, including representatives from national third sector organisations predominantly focused on health, national third sector organisations who provide registered social care services, and TSIs. The event sought to explore what participants hoped joint strategic commissioning would achieve, to identify what barriers exist, and to debate potential enablers to overcoming these barriers. **Section 3: Improving Strategic Commissioning** provides more information on this.

Some of the barriers identified included:

- Lack of trust.
- Fear over survival.
- Competitive tendering.
- Competitors.
- Varied sector.
- Cynicism/nothing changes.
- Change process.
- Role of TSIs.
- Funding arrangements.
- Lack of resources.

Some of these, such as uncertainty about the role, structure and purpose of the TSI within integration, may be partially addressed through using this handbook. Others will require work at local level to agree on how they are to be addressed.

There is also a role for national organisations such as VAS, CCPS and ALLIANCE to enable the wider third sector to engage with integration in a coherent and co-ordinated manner. It is hoped that the production of this handbook will contribute to this. As TSIs and local partners define their roles and start to work on behalf of the third sector, this will in turn help to create a clear path towards ensuring that Integration Authorities can collaborate productively with the third sector.

A full copy of the dialogue event final report can be found here:
http://www.vascotland.org/wp-content/uploads/2014/12/Third-Sector-Integration-Dialogue-06.10.14-final-report.pdf

1.4 Background to Integration

If health and social care integration is a new area of work to you, or if you haven't had a great deal of interaction with those leading integration in your area, then you may benefit from the **Background to Integration appendix** included in this handbook.

The appendix gives an overview of the legislation, the policy context, and details of the health and social care outcomes. It also contains links to all the statutory guidance with which Integration Authorities have been provided to develop integration from policy into practice.

1.5 The Principles of Integration

The principles of integration describe what integrated care is intended to achieve, and underpin how services should be planned and delivered.

Building on the priorities outlined in the 2011 Christie Commission's vision for the future of public services, the integration planning and delivery principles set out the expectation of a culture of respect and genuine engagement in the planning and delivery of person-centred, high-quality integrated care.

The principles are intended to be the driving force behind the changes in culture and services that are required over the coming years to deliver reforms successfully and improve outcomes. They explain what people using services, and their carers, can expect from

integrated services, as well as the behaviours and priorities that are expected of organisations and of the people planning and delivering care and support.

Services will be provided in a way that:

- respects the rights of service-users;
- protects and improves the safety of service-users;
- improves the quality of the service;
- best anticipates needs and prevents them from arising; and
- makes the best use of the available facilities, people and other resources.

Services must be:

- integrated from the point of view of service-users; and
- planned and led locally in a way that engages with the community (including in particular service-users, those who look after service-users, and those who are involved in the provision of health or social care).

Services must take account of:

- the particular needs of different service-users;
- the participation by service-users in the community in which service-users live;
- the dignity of service-users;
- the particular needs of service-users in different parts of the area in which the service is being provided; and
- the particular characteristics and circumstances of different service-users.

Note: These principles are a single set of shared values which, taken as a whole, span all activity relating to health and social care integration.

These principles will be a useful cornerstone for TSIs and others to use to focus the work of Integration Authorities on the needs of local communities and to ensure that Integration Schemes and the commissioning work that supports them remain focused and on track.

http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Principles

1.6 What Is Being Integrated?

This national agenda requires the local integration of key parts of adult health and social care services. Integration does not mean that the entirety of health and social care services in an area are included in an Integration Scheme. Some aspects of health services and social services will remain outside of the integration work.

Guidance from the Scottish Government states that the Integration Schemes should include key services that are focused around long-term or ongoing illnesses, conditions or situations. These are services that are for adults and older people. A full list of what should be included can be found in the Guidance Documents.

Statutory partners (Health Boards and local authorities) must consult locally and then decide whether to include services in their integrated arrangements aspects of children's health and social care services, criminal justice social work and housing support.

This means that each area's Integration Scheme will depend on local choices, and that any advice or support from external sources will need to be tailored by those involved to suit that area. This includes the contents of this handbook.

The stated priority for integration is improvement:

- Improving people's experience of health and care services.
- Improving the personal outcomes that services and other community assets achieve.

– in particular, improving quality and consistency across Scotland while allowing for local approaches to service delivery.

Note: Part of integration is about culture change and the combination of perspectives from both the medical and social models of health and disability, and these may take some time to reach a comfortable fit.

1.7 Implications for the Third Sector

The Scottish Government considers the third sector to be a key partner for Integration Authorities: throughout the regulations and supporting documentation, a variety of places for the third sector are described:

- Supporting guidance on 'The Role of the Third Sector Interfaces' recommends that the TSI has a place on the board of the Integration Authority, on behalf of the wider third sector.
  The guidance can be accessed here:
  http://www.gov.scot/Resource/0047/00475591.pdf
- There are also a number of third sector places on the Strategic Planning Group and on Locality Planning Groups. Each area must decide locally who will fill these places.

Throughout this handbook we describe how we think the TSI could shape its role, as well as the factors that need to be considered when doing so. We also provide some useful information about approaches the TSIs might take to deliver that role effectively for the third sector.

The third sector has many connections into health and social care for many different reasons and on behalf of different groups of people. All of these relationships are likely to be altered because of integration, whether because there is a new Integrated Joint Board

for the sector to connect with, or because the emphasis of their Integration Authority will be different owing to the shift of focus on to quality and outcomes.

Integration will have an impact on:

Providers of health and social care – up to 35–40% of social care services in any given area are contracted to providers from the third sector. As a result of changes to processes, priorities and relationships, as well as a further shift towards the increased use of self-directed support and outcomes-based commissioning, this part of the third sector is likely to be significantly affected.

Patient and user groups – across Scotland there is a multitude of informal peer support groups that are organised around shared experiences of a particular health condition and/or the use of a particular service. Many of these are well established and are part of broader networks, e.g. a local branch of a national charity, whilst others are small, local and not necessarily networked with other groups. With a focus on engaging with patients and service-users, the new integration arrangements are likely to make significant demands on some of these groups.

Local community groups – Integration Authorities will have to undertake *meaningful engagement* which takes account of people in a locality who currently use services or are more likely to use services. As a result, many other community groups are likely to be asked to become involved in the work of the Integration Authorities.

Housing support – housing associations and providers of support in the home are often part of the third sector, and are likely to be key partners in the preventative approaches that are developed and implemented by integration.

1.8 Connections across Community Planning

Integrated health and social care will be a key component of the local community planning structures. Some Community Planning Boards have already adapted their structures to place their Integration Authority as a body that reports to the Community Planning Board.

The existing position of the TSI on the Community Planning Board puts it in a strong position both to encourage change and to constructively champion or question the plans of the Integration Authority as they are reported to the Community Planning Board – specifically around areas such as reducing inequalities and improving outcomes.

It is important to note that, while part of the activity aimed at reducing health inequalities will be undertaken by the Integration Authority, responsibility for creating a strategy in this area sits with the Community Planning Board. It is expected that other areas of work covered by the Community Planning Board will also contribute to reducing health inequalities.

As other areas of community planning adapt and grow over the next few years – e.g. community justice, community empowerment, community learning and development – it may be that the TSI will be able to use its existing partnerships, relationships, networks and

approaches to increase the impact of the third sector on all of these areas, transferring learning and the trust established from one policy area into another.

TSIs are well positioned to 'connect' broader third sector work to the health and social care agenda. Areas such as housing, income poverty, welfare reform, fuel poverty, leisure and social activities, environment, transport and equalities will all be important when thinking about integration in its broadest sense and opening up the ongoing conversation about influencing and improving outcomes. This is not an exhaustive list, however, and TSIs may be aware of other themes or organisations which may have a role to play locally.

Note: Audit Scotland recommends that local authorities and the NHS work effectively with the third sector to analyse local needs and to plan, then develop and deliver, services to meet these needs.

This principle is also acknowledged by the Scottish Government in guidance on procurement in social care and support, and is likely to be integral to the role of the third sector within local partnership structures.

1.9 Catalyst for Change

In his budget statement of 11 September 2013, the Cabinet Secretary for Finance and Sustainable Growth announced that £100m would be made available to local partnerships in 2015/16. This would form the *Integrated Care Fund (ICF)*.

On 19 March 2015 it was announced that a further £200m would be allocated to the ICF for 2016/17 and 2017/18.

The aim of the ICF is to support the implementation of integration locally and to allow partners to focus on *preventative care* and *early intervention* as well as on support for people with multiple and long-term conditions.

Each area has approached the allocation of the ICF differently, and the allocation to the end of 2018 may, in some cases, still be influenced. Once a TSI has completed the tools it thinks are relevant from this handbook, it can use **Section 6: Resourcing a Local Case** to put together a case for the local resourcing necessary to develop third sector engagement with integration.

Previous experience of change funds, particularly *Reshaping Care for Older People (RCOP)*, has led to concerns about the ability of the third sector to influence and shape how funds are used and about how any innovative models and the delivery of improved outcomes fail to secure ongoing funding. There is a perception that this is because the 'system' is unable to identify and free up savings.

Evaluation Support Scotland (ESS) has published a number of documents highlighting the valuable role of the third sector in RCOP. *These can be accessed from ESS's website here:* http://www.evaluationsupportscotland.org.uk/how-can-we-help/shared-learning-programmes/stitch-time-publications/.

Also, VAS, ALLIANCE and CCPS developed an assessment framework (previously distributed to TSIs) for the first year of the ICF. Both of these sources may be useful for TSIs to refer to when considering how the ICF is used in Years Two and Three; and it may assist TSIs, and the third sector as a whole, to influence their Integration Authority's future priorities for investment using the ICF.

2. Defining the Role of the Third Sector and the TSI

This section outlines an approach that TSIs can take to shape and define their role within integration – bearing in mind the external pressures and expectations created by legislation, guidance and relationships with other parts of the third sector.

In delivering integration, all the partners within the new integrated structures are taking on new roles. The goal is to deliver existing responsibilities in different ways, to innovate and to refocus the efforts of services, processes and resources. This aims to improve service quality and outcomes for people locally in line with the National Health and Wellbeing Outcomes. *A copy of the outcomes can be accessed here:* http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes

To achieve this, it is likely that the Integration Authorities will need to make conscious efforts to increase the benefits of collaboration and coproduction and to overcome any inertia in relation to existing practice. This will require all involved to take a constructive and engaging approach, making the most of the strengths and assets of each of their organisations and sectors and combining them in such a way that they are able to make enough difference to overcome the cynical view that 'nothing changes'.

Note: A similar approach should also be taken by any local third sector health and social care network or forum facilitated by the TSI for the purposes of this work.

The TSI has been specifically named in an Advice Note, published by the Scottish Government, as being best placed to be the conduit between the Integration Authority and the wider third sector. *A copy of the Advice Note is available here*: http://www.gov.scot/Resource/0047/00475591.pdf

In work undertaken by ALLIANCE, CCPS and VAS in late 2014, we identified that the TSIs would have to be aware of and address areas for improvement. Some of these are discussed in this handbook; others will be need to be explored and resolved over time.

There is a view that the key to success for integration is more about behaviour than policy: that there is sufficient legislation and public policy across many areas of public service that could transform the way people live. These could improve people's health and enable them to make the most of services that are supportive, connective and focused on their needs.

The third sector has an opportunity to contribute to changing these organisational behaviours so they become focused on people rather than systems. At the same time, it can support and develop its own contribution to shaping and delivering better services and outcomes. In order to do this effectively, the TSIs and the wider third sector should work constructively with their Integration Authorities to bring about change. How they achieve this together will be key.

2.1 The Role of the Third Sector

The role of the third sector in the new integrated structures is not temporary or one-off: the third sector is defined in legislation and guidance as a key partner across integration. The sector will be required to operate in a number of different ways and at different points within the structure.

The regulations and guidance supporting the Act define multiple roles for the third sector:

- a place on the Integrated Authority for the TSI;
- a place on the Strategic Planning Group for non-commercial providers of health care;
- a place on the Strategic Planning Group for non-commercial providers of social care;
- a place on the Strategic Planning Group for non-commercial providers of social housing;
- a place on the Strategic Planning Group for third sector bodies carrying out activities related to health or social care;
- a place on the Strategic Planning Group for users of both health care and social care services and their carers; and
- a place within locality planning for community organisations.

The Scottish Government's 'Strategic Commissioning Plans Guidance' specifically states that:

> *"It is vital that the full extent of the third sector's knowledge, expertise and information, both in relation to communities and the sector itself, is brought to bear upon strategic commissioning and locality planning in order to achieve the outcomes of health and social care integration. This will require all parties to work with trust and mutual respect."*
> (p.18)

A full copy of the Commissioning Guidance can be accessed here:
http://www.gov.scot/Resource/0046/00466819.pdf

Key links between the third sector and the Integrated Authority are likely to involve multiple and complex relationships and interactions across the third sector, and between the third sector and the Integration Authority. Many of these links will already be in place, and others may need to be built as part of the process over the next year. It is already clear that the TSI does not have to connect to everyone, but should be aware of what is happening. This is covered in more detail in the **Partnership-Mapping Tool** in this handbook.

Note: Using the partnership-mapping tools in this section will help identify where those pieces of work should or could best sit as the TSI builds its role as partnership broker.

2.1.1 Co-ordinating these Roles

The TSI has a key role to play in in co-ordinating the diverse roles of the wider third sector in integration and supporting the sector to operate effectively within, and influence, integration locally.

The rest of this section focuses on shaping how the TSI can define and deliver this role.

2.2 Framing the TSI Role

Generally, the TSI's role within integration, and the nature and extent of its relationships with local partners, will be dependent upon existing local working arrangements. Although integration brings a more formal expectation of involvement and engagement, the details will, in part, depend on how partners currently view each other and the nature of previous work between them.

The Scottish Government Advice Note on 'The Role of Third Sector Interfaces' identifies five key aspects to the TSI's role:

- Joining up and activating parts of the third sector and volunteers to support health and social care outcomes.
- Developing a strong third sector engagement strategy to support strategic planning and joint commissioning.
- Advocating the interests and conveying the intelligence of the third sector at the Integrated Joint Board.
- Mapping more clearly and connecting third sector organisations able to contribute to health and social care policy development or with valuable intelligence to add.
- Supporting the exploration of the third sector role in enhancing prevention, self-management and co-production.

Note: The Advice Note explicitly states that some of these aspects will require additional local resourcing to enable them to happen and to be effective.

As noted above, the TSI then has a dual role:

- as the **third sector advocate** on the Integration Authority's board; and
- as a **partnership broker** of third sector engagement across integration.

Note: For more information on the role, responsibilities and membership of the Integrated Joint Boards, please refer to the Scottish Government's recent Guidance and Advice Note here: http://www.gov.scot/Resource/0048/00484578.pdf.

When adequately resourced, the TSI can work with the broader third sector to support the Integration Authority to lead change and to offer the sector's strengths and assets to improve outcomes for communities and people. The partnership that the TSI will need to build across the third sector is likely to operate at different levels and engage with the Integration Authority at different times and for different purposes.

Having an overall picture of who is involved, and why, will be important for this local third sector partnership. From this overview it will be able to identify which groups, clusters or individual organisations have the capacity, interest and knowledge to engage in particular pieces of work.

Through this role the TSI can support the local third sector partnership to unlock the potential contribution of the third sector as well as support, promote, develop and advocate on behalf of the third sector.

Note: It should be stressed that the TSI's role is not to represent every concern in the third sector, nor is it to represent the patient or service-user's voice, within integration. The TSI role is focused on third sector organisations.

In the past it has often felt impossible for local third sector organisations to have a real influence on the health and social care agenda because that agenda is so vast and complex. Influence may be more likely going forward though. This is particularly due to the TSI's having a place at the Integration Authority table and a role to advocate for the wider third sector, plus several third sector places in the Strategic Commissioning Group and arrangements for meaningful engagement across sectors.

Taking these expectations and aspects into account, the role of the TSI within integration then becomes one of a *partnership broker*. This is a more significant role than combining existing partnership work with brokerage skills. For the TSI this is about approaching partnerships in complex systems and combining a number of skills in a different fashion.

In some areas TSIs already act as brokers; by hosting, facilitating and supporting third sector organisations in their areas to come together as local Health and Social Care Forums. These have various structures, processes and approaches that are tailored to local area needs, but in each case the TSI is the organisation that connects, enables and develops the third sector to engage with health and social care. In other areas this is co-ordinated by a local authority, so the structure and purpose may be familiar.

In the previous work undertaken by VAS, CCPS and ALLIANCE it was identified that there are three sections of the third sector likely to have an interest in this work:

- community and voluntary organisations;
- third sector providers of health/social care services, both smaller local providers and larger national providers; and
- patient and carer organisations.

Between them these different sections of the sector make up a significant portion of the contacts TSIs already have within their communities. However, the TSI is not the only organisation that works with these groups, and each individual group is likely to have

multiple relationships that capture and share the knowledge, capacity and intelligence of the sector. In order to avoid too much duplication, the role of the TSI will be to connect, develop and champion the third sector organisations to participate in the processes and structures of integration and, through this, to contribute to the health and social care outcomes.

2.3 Creating a Start Point

The creation of a start point from which third sector organisations in an area can work together and fully engage with integration is an essential component of the broker role. Creating this start point is likely to include bringing together all interested parties and:

- defining the level of knowledge, awareness and understanding across the sector – and ideally securing an undertaking from the most knowledgeable to share this and bring others up to speed on what they know and what has happened so far;
- agreeing a set of fundamental principles that the third sector locally can use to inform their contribution to joint strategic commissioning discussions, whether this is by those taking part in the joint strategic commissioning group or by others working across the sector. Publishing these principles will ensure transparency to other parts of the sector not involved in health and social care;

> **Note**: The Act provides a set of principles for the NHS and local authorities to plan from. Whilst these may be a useful starting point, the discussions amongst third sector organisations should focus on the principles to which it as a sector would like to hold itself accountable in this area of work.

- developing a local framework for sharing assets, knowledge and data that can be used by the sector to inform strategic commissioning decision-making, and by the Integration Authority to inform work in improving outcomes; and
- understanding the governance role that the sector holds within the Integrated Authorities; in particular, understanding and using the mechanisms put in place by the Authority's standing orders in order to ensure that the right questions are asked at the right place, within the right time frame, so as to be effective.

The rest of this section explores the roles detailed above in more depth and provides a series of tools that can be used to strengthen the role in a methodical fashion.

2.4 Partnership Brokering

Being a partnership broker moves the focus of efforts towards managing a system instead of delivering the component parts – so that it enables inputs from across the third sector and increases the influence of the sector. This is not about doing everything at the front line, but is more focused on supporting those on the front line to advocate on behalf of the whole sector – in other words, on enablement and connection across the sector.

It may however be the case that some front-line efforts by the TSI are required to get things started, which may then be withdrawn over time as others are supported and enabled to take on the responsibilities. This will require the TSI in its broker role to have an ongoing, up-to-date overview of how the work is progressing and of what development is required at each stage.

Being a partnership broker assists the TSI in its core role of supporting, promoting, developing and advocating the interests of the third sector locally.

The key attributes of being an effective partnership broker include:

1. Co-ordinating diverse voices
2. Connecting
3. Synthesising and hosting information
4. Communication and presentation
5. Capacity-building
6. Reviewing and revising

If these attributes (which are explained further in the following six subsections) are delivered in ways that prioritise co-production, asset-based prevention, self-management and intelligence-led service improvement and innovation, the TSI and third sector can lead by example.

The TSIs need to occupy a position that enables them to lead on behalf of the third sector whilst dealing with the complexity, ambiguity and developing nature of new systems being established by the Integration Authorities. In order to inform this leadership position, the TSI will have to work across the sector to make the most of its diverse strengths and experiences and ensure that these are used to inform contributions across the integrated structures. This will include enabling and supporting individuals to be the third sector 'presence' at various meetings rather than the TSI having to attend every meeting on behalf of the sector.

The need for consensual, resilient and stable leadership within and across the third sector will become increasingly important as the changes brought about by strategic commissioning start to be felt. The development of a high-level role for TSIs in integration becomes a necessity when we consider some of the challenges they face in this area. These include, in particular:

- tightening financial constraints;
- a lack of understanding from some of the partner organisations and about the roles and functions of the TSIs; and
- the challenges for TSIs of participating in an increasing number of partnerships without the additional resources to do so.

From this start point the TSI will then be able to explore and deliver on the core aspects of being a partnership broker.

2.4.1 Co-ordinating Diverse Voices

In a complex partnership such as health and social care integration the TSI will need to be able to gather, understand and reflect a diverse range of opinions and voices on a broad range of related topics.

Speaking from diversity: speaking and acting on behalf of the third sector. Putting forward the range of views, values, ideas, beliefs and practices that are shared across the sector. It is essential to be clear that there is rarely a single absolute opinion from the sector and so the TSI needs to give weight to both the commonality of opinion and strength of opinion as expressed by different parts of the sector – even when these views seem at odds with each other. This means communicating the clusters of opinions, and, where they are apparent, the connections between them, to help others understand the broad range of views that exist. There is also a role here in asking the questions that are raised from the sector of those on the Integration Authority, in order to strengthen transparency and accountability.

Advocating: increasing the understanding of and support for the third sector across the Integration Authority both generally and with individual partners. Increasing the presence of involvement of the third sector in the processes of the Integration Authority – the focus here is on quality rather than quantity, so that the third sector is considered to have parity of esteem rather than just being given a 'seat at every table'.

Negotiating: securing agreement requires negotiation; however, in a complex partnership, this is not negotiation in the sense of a business deal. A partnership broker focuses more on creating the opportunity for the interests of all parties to be identified and discussed in a purposeful way that aims at building consensus and complementarity out of diverse aspirations.

2.4.2 Connecting

Successfully convening, connecting, mapping and building relationships between the integration structures and the third sector – particularly in the early stages – will require the TSI to manage a range of encounters between key players who may not previously have worked together at all and/or may be suspicious of each other. This will involve creating new opportunities for third sector organisations to meet and to start forming new collaborations.

Once these relationships have been established, the task will move on to connecting third sector delivery into the co-production of any clinical or service pathways that are created by Integration Authorities. Creating these connections between statutory and third sector services should help to:

- increase the ability of both sectors to reach those whom some consider 'hard to reach' but who may in fact be the daily contacts for third sector organisations – traditionally these are viewed as older people, disabled people, people who rarely use services, etc.;
- start prevention activities earlier, contributing to improved health outcomes;
- provide support more holistically, contributing to improved wellbeing outcomes; and
- provide people-focused health and social care services that are built around people and communities and their priorities.

In building these connections, a range of encounters may have to be established. These could be one-to-one meetings, small group activities, or larger-scale events, all of which TSIs are already highly experienced in delivering. This could include signposting to what is also happening elsewhere – whether learning from emerging practice in another part of the country, or connecting in to things that national organisations are doing.

However, making connections in complex partnerships can require using these in different ways, or generating a deeper understanding of what relationships currently exist and why.

Some examples include:

Mapping of relationships:

The TSI is the conduit between the integration structures and the third sector for the Integration Authority. It is also one of a number of third sector members of the Strategic Commissioning Group and Locality Planning Groups. As a result it will have to understand the depth and range of relationships required to achieve the task of improving outcomes. Some of these relationships will already exist, some will need to change in nature, and others will need to be established from scratch.

> **Note**: Mapping the existing relationships across the two systems is likely to be an early task.

Collaborative relationship-mapping creates a graphic/visual reflection and assessment of the nature of existing partnerships, relationships and networks. It can be used to generate an assessment of, and document the development of, human and social capital devoted to a partnership.

This approach considers partnerships as a set of collaborative relationships, where collaborations are interconnected sets of relationships, networks, groupings and coalitions, and considers the different types of collaboration across a network.

It will be important to recognise that some parts of the sector may not currently be 'in the loop' and may require additional effort to reach and persuade them to participate. Some of the disability organisations, equality groups or service-user-led organisations in particular may require additional efforts or may require access issues to be addressed in order to be appropriately engaged. There will be learning from other projects, such as the Inclusion Scotland project on engaging disabled people's organisations, which can add to understanding as this work progresses.

An approach to collaborative relationship-mapping is outlined in **Tool 1**.

Considering readiness for change:

A key aspect of integration is to change the decision-making process regarding what services are delivered in a locality. This, coupled with the changes to the strategic planning and commissioning processes, requires significant change not just within statutory agencies but also within some of the third sector organisations, e.g. those that have become almost 'part of the system', in order to secure service delivery contracts or act as local representative voices for groups of service-users. These organisations in particular may have their current

positions and relationships challenged by others as the focus shifts away from what has been done to what should be done.

A willingness to change what they do and how they do it will be a prerequisite for all cross-sector organisations engaging with integration. Establishing readiness for change within complex partnerships can be difficult to achieve, but if the barriers to change are not identified then the work of others can face significant inertia, leading to the cynicism that often impedes change.

Two approaches to Assessing Change Readiness are outlined in **Tool 4** *and* **Tool 5**.

Convening and building relationships:

Using existing knowledge, and any new intelligence gained from the techniques above, the local third sector partnership will be able to establish what range of relationships need to be built or reconfigured in order to meet the needs of integration locally. It is likely that the TSI will facilitate this collaboration in the first instance, then support the sector to continually identify its needs over time.

The aim of relationship- and partnership-building across the third sector is to create partnerships that support expertise-groups from within the sector itself to take a seat at different places within the work of the Integration Authority, rather than the TSI occupying each of these seats itself. Therefore the focus of this relationship-mapping and -building should be on increasing the capacity within the sector and preparing the Integration Authority for working with the sector in partnership.

Relationship-building through joint working:

A key aspect of the learning from the VAS *Community Planning Improvement Programme* was the value partnerships placed on the input of independent facilitators in the process. The use of external facilitation enables groups of partners to explore an issue, or set of issues, in a structured manner while being led by someone who has no strong 'stake' or 'view' on the issue.

> **Note**: If the TSI has managed to occupy the position where it is a partnership broker, it may be able to take on the role of independent facilitator. If that is not possible then the TSI could approach others who are less likely to be considered to have a stake in the outcome of such a dialogue.

The use of a particular approach should match the purpose of the discussion but it needs to be kept fresh to hold participants' interest. The use of collaborative learning approaches have proven to be effective for other areas or partnership work.

Tools

An approach to the improvement technique used can be found in the CPIP training, available from the Improvement Services' website:
http://www.improvementservice.org.uk/phone/index.html

The Scottish Health Council has developed an engagement toolkit which could be used to ensure that a range of engagement mechanisms are available to establish and build relationships:
http://www.scottishhealthcouncil.org/patient__public_participation/participation_toolkit/the_participation_toolkit.aspx#.VgpbR99Viko

Whilst not comprehensive, this set of tools is intended to be used to consider the creation of a start point for connecting with the right people. It is likely that any tool will require adaptation for use in local circumstances.

2.4.3 Synthesising and Hosting Information

Partnership brokers need to be highly capable of managing complex data and layers of information and experience. In addition they need to ensure that meticulous records are kept of meetings and decisions, either by themselves or in overseeing someone else in undertaking this important function.

Across an Integration Authority there are likely to be a wide variety of meetings held, at various levels of detail and complexity, on a broad range of topics – from locality planning through to commissioning plans and processes, through to resource allocation and preventative approaches.

Managing the flow and volume of information on behalf of the third sector is likely to be a major task for the TSI. Managing this information so that it is accessible and meaningful to different parts of the third sector – making it *intelligence* rather than just *information* – is the key task of a partnership broker. The key to this is **synthesising information**, not just handling and storing it.

Synthesising involves combining information, perspectives and ideas and enabling an evolving understanding of the continual flow of information – it is not a static collection/distribution process. Real synthesis occurs as a reader summarises what has happened and gives it personal meaning – creating original insights, perspectives and understandings by reflecting on text(s) and merging elements from text and knowledge from elsewhere. In integration this will include blending the perspectives and adding value from third sector providers, patient/user groups and communities.

In addition to strong information-synthesising skills, TSIs are likely to implement a robust system of record-keeping and **information-hosting** – a key aspect is tracking the source and flow of information between systems and partners.

Note: Robust agreements about sourcing, sharing and the availability of information across those involved from the third sector should be established early and should be adhered to strongly.

Within the Integration Authority:

As a public authority, much of the information that the Integration Authority generates, manages or hosts could be regarded as publicly accessible unless otherwise stated.

Some documents from the Integration Authorities ***have*** to be made public, and some ***have*** to include a range of partners in their development. However, the TSI may want to push for as open-access an approach as possible, so that all partners can gain maximum value from the information that they contain.

There will be a series of minutes, notes, presentations, background papers and other papers that relate to a large number of meetings. Storing these in a way that makes sense is important, so that people know where to look for what is important to them.

There are also issues regarding accessibility – some service-users will be people who find written documents difficult or impossible to access and/or make sense of; this may be people with learning disabilities, people with sight impairments, or for other reasons. As a result, access in a range of formats is something that the Integration Authority should consider in order to make sure that everyone can make a relevant and meaningful contribution to integration.

Across the third sector:

The TSI will work across different parts of the third sector in order to make sense of integration and to develop a set of positions for use in supporting, promoting, developing and advocating the interests of the third sector locally. Consideration should be given to the storage and distribution of this information, so that all involved are able to access what they need when they need it.

The TSI as part of its partnership broker role may also wish to encourage the sharing of data amongst statutory and third sector organisations – creating a 'data hub' that all partners can contribute to and benefit from. A data hub of this type could include a wide range of inputs, most of which are included in **Section 4: Gathering and Using Data**.

The systems for gathering and sharing data will be unique to each area so there is no standardised version of a library of records, but there are some key things to consider:

- Hosting all documents online in a SharePoint library (or similar) for ease of use, access and distribution. If used well, this can significantly reduce the efforts required to get the right information to the right people at the right time.
- Creating meta-data – explaining what documents/information are and how they relate to different areas of the Integrated Authority's work. Contextualising information in this way helps provide a useful map of what is important to each area of work, and assists with drawing the links between different areas of work.
- The use of specific systems to manage and share information is likely to be something that requires a system with more access to third sector partners than the

online database MILO (see Section 4.3.2) as it is. However, there may be adaptations that a TSI can make to its existing systems to facilitate the gathering and sharing of relevant information.

2.4.4 Communication and Presentation

In undertaking the role of partnership broker it will be essential for the TSI to utilise the full scale of communication skills – social interaction, active listening, empathy, concise speaking, ability to tailor written communications to different audiences, and conducting meaningful conversations. It is likely that the TSI will have to present the idea of partnering and building collaborations, or details about the partnership itself, to many different audiences, from small service-user groups to statutory boards. Achieving this will require good storytelling and presentation skills, as well as networking skills.

Another key aspect of communication will be taking the information about what is happening locally (synthesising information, as explained above) and communicating it outside your area to other interested parties. This could include:

- Case studies and examples of emerging practice for sharing across the network of TSIs.
- Sharing information on how your local third sector is developing as deliverers of health or social care services – both number/types of contracts secured and approaches to delivery.
- Explaining the third sector's approach to and engagement with prevention – particularly around what is working well and how it is demonstrating outcomes.
- Linking with national third sector organisations who may be able to facilitate the sharing of useful intelligence that informs local work, and vice-versa.

Further Information

Most of this type of skill development is available elsewhere so is not covered in depth in this manual.

An example of approaching communications in partnerships strategically is Talking the Walk: A Communication Manual for Partnerships Practitioners, developed by The Partnering Initiative:
http://c.ymcdn.com/sites/www.gbsnonline.org/resource/collection/C6833BC0-02C0-42E2-8804-5FAB1D3B217B/TalkingTheWalk.pdf

2.4.5 Capacity-Building

As a partnership progresses, the local third sector will likely have a new focus – facilitating the sharing of responsibilities across partners. This may involve stepping back from every front-line role and working in the background to support and coach individual partners or people in building their own partnership working skills. Which people and organisations are able to contribute to the different aspects of the work will vary depending on local circumstances, and TSIs should facilitate the engagement of local and national expertise from within the sector where possible.

Taking this approach eases the pressure on the TSI to deliver everything directly on the front line and enables it to focus its efforts on developing sector-wide capacity to engage with the integration system.

The TSI has a crucial role in increasing the engagement of organisations from the Integrated Joint Board with people from across the local third sector. TSIs may also need to help build governance and accountability procedures as the local third sector network itself becomes more 'institutionalised' in the ways of the Integrated Joint Board, as the Board develops its work over the coming years.

Similarly, as a key partner in the Integrated Joint Board itself, the TSI will have a role to play in establishing the Board's approach to partnering, including the governance and accountability of the Board.

Taken together, this creates a role for the TSI in building a two-way relationship between the local third sector and the local Integrated Joint Board so they are capable of full and detailed collaboration – building the local infrastructure that makes sure people's outcomes are being met and improved by local health and social care delivery and other work.

There is already a range of structures and partnerships in existence that support the interaction between health, social care and the third sector. But integration creates a new set of structures to engage with, and may broaden out the range of topics, change the physical communities, or incorporate new groups of patients and service-users. It may be that a TSI can easily connect its existing involvement structures to these new structures.

But this is an opportunity for the third sector, led by the TSI, to renew and refresh its structures, building in new accountability or new 'representation' mechanisms to refocus the work on the people-focused outcomes and the more general health and wellbeing outcomes.

TSIs are well versed in capacity-building approaches for the sector, so this is not covered in depth in this manual.

2.4.6 Reviewing and Revising

To ensure that the focus remains centred on improving service quality and outcomes, the TSI may have to regularly review and refocus its efforts and those of others involved from the third sector. Doing so will require:

- working across the third sector to understand and differentiate the underlying interests of different parts of the sector, so that the TSI can include this as part of co-ordinating diverse voices; and
- keeping the focus on health and wellbeing outcomes for people, which will help maintain focus within strategic discussions. If the opposite happens, and service delivery/contracting procedures/data processes become the focus of discussions, then the strategic discussions are at risk of moving away from the quality and outcomes focus.

Any partnership benefits from regular reviews to ensure that each partner remains animated and the process of collaboration does not lose momentum. As a body in a unique position and with unique knowledge of both sides of the integration work, the TSI will be

singularly placed to facilitate reviews itself (or, if it is seen as too close to the partnership to do this objectively, to brief someone else to facilitate the review on behalf of partners).

Using the tools from other parts of this handbook, you can track progress on how:

- relationships are strengthening;
- decision-making is shared;
- partners are communicating at each level (strategic, commissioning, and locality);
- information from various sources is reaching those who need it; and
- people and organisations are readying for, accepting or implementing change.

Depending on the timing of these reviews, the partnerships themselves will be able to establish how they are progressing on improving people's stated outcomes, through:

- reports on National Health and Wellbeing Outcomes;
- reports from service-providers, whether statutory, private or third sector;
- national quality survey of healthcare; and
- experiential perspectives from individuals or groups of service-users.

Taken together, these elements of review can form a revised approach for:

- the Integrated Joint Board – at strategic, commissioning and locality levels;
- the local third sector; and
- individual partners.

The partnerships can then use this information and experience, including analysis of trends, to inform future integration work that the TSI and third sector participate in, including both:

- how the partnerships are operating and areas that they could or should improve; and
- how the integrated health and social care system is operating and how that could or should improve.

It is important to recognise where a revision of partnership working is likely to have a positive effect on the health and social care outcomes. Where there are many changes that could be made, focusing in on those that are likely to have an impact on the outcomes, rather than on those that feel as if they would be quick or easy to achieve, is likely to help prioritise.

Further information on potential data sources to support this area of work is available in **Section 4: Gathering and Using Data.**

Note: The tools outlined next in this section are included as suggestions. Alternatives are available and may be preferable to local third sector partnerships.

The tools are intended to assist the facilitation of the widest possible engagement of those across the third sector who believe they have a contribution to make.

Tool 1 – Identifying Partners and Relationships

There are a number of ways of identifying the broad range of partners that should, or could, be included in the work in integration.

Attention should be given to making sure that people and organisations from the three parts of the sector are included:

- local third sector organisations (whether or not they are health/social care-specific);
- health/social care organisations with a local presence; and
- third sector providers of services – whether via contract/grant with either the Health Board or local authority and/or those regulated by the Care Commission.

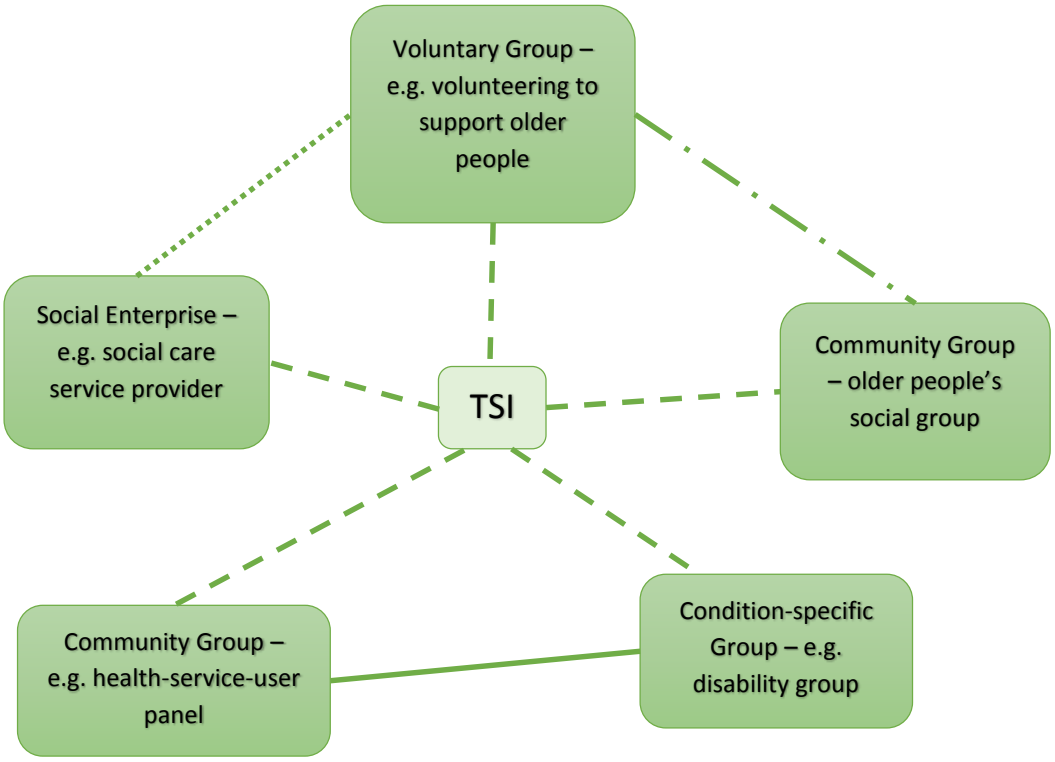
A distinction can be made between the purposes and nature of partnerships. Partnerships may usefully be seen to range from networking through to collaboration.

- **Networking** involves the exchange of information for mutual benefit. This requires little time and trust between partners. *For example*, Youth Services within an area may meet monthly to provide an update on their work and discuss issues that affect the health of young people.
- **Co-ordinating** involves exchanging information and altering activities for a common purpose. *For example*, Youth Services may meet and plan a co-ordinated campaign to lobby for more disabled youth-specific services.
- **Co-operating** involves exchanging information, altering activities and sharing resources. It requires a significant amount of time, a high level of trust between partners and the sharing of 'turf' between agencies. *For example*, a group of secondary schools may pool some resources with a specific health charity to run an 'Awareness Week' as a way of increasing awareness of a specific health condition and encouraging the uptake of preventative activities.
- **Collaborating** involves exchanging information, altering activities, sharing resources and enhancing the capacity of the other partner(s) for mutual benefit and a common purpose. Collaborating requires the partner to give up a part of their 'turf' to another agency to create a better or more seamless service system. *For example*, *Family Buddies* in East Ayrshire is a Public Social Partnership that brings together a range of partners to provide holistic and person-centred support to young families in need. Through effective collaboration the partners continue to operate as autonomous organisations but they also work as a cohesive unit, providing seamless support to those who need it. The project co-ordinator is seconded from the local authority to the TSI so that she has access to the knowledge, skills and expertise of the TSI in supporting the project delivery.[1]

[1] For more information on the Family Buddies project, please refer to the case study published by VAS : http://www.vascotland.org/wp-content/uploads/2013/09/Family-Buddies-Case-Study-CVO-East-Ayrshire_FINAL_VAS_070515.pdf

It is possible to map out the relationships to gain a visual representation of the number and types of organisations involved in each of these partnerships. The process to follow is this:

1. List all the agencies involved in the partnership. The Lead Agency (the TSI for example) can be placed in the centre.
2. Using the legend below, link the agencies in terms of the nature of the relationship between them. The Lead Agency is likely to have a relationship with all of the others; however, there may also be important links between partners that do not rely on the Lead Agency.
3. The strength of the links between partners should be based on evidence of how the partnership actually works rather than how people might like it to work or how it may work in the future. Where possible, cite concrete examples as evidence of the strength of the coalition.



Networking	
Co-ordinating	
Co-operating	
Collaborating	

The mapping exercise is designed to place all the partners in relation to each other. Lines are drawn between them to show the strength and nature of the relationship. Mapping the relationship is a way of clarifying roles and the level of commitment to the partnership. This is important because partners may have different understandings or expectations of what their involvement means.

The above example is a simplistic version of what will happen. The real version – your version – will include a far larger number of organisations and could include a tiered structure, where organisations are clustered around any sub-groups that they are part of, where those sub-groups then form the partnership. In reality the TSI may not be the central focal point; a third sector health and social care partnership may be the 'hub' instead.

You would create this as a participative exercise and use a 'sticky wall' to gather the detail. This may also help to identify where new relationships need to be built or maintained in the new approaches adopted by integration.

If done collectively, this exercise can help to strengthen a partnership because people are able to highlight areas of concern. It will also provide an opportunity to address areas in which there is a lack of consensus.

It is interesting to note patterns in the relationships and how these change over time. Many partnerships are strong on networking and co-ordinating but considerably weaker on collaborating. Completing the map provides an opportunity to look at ways in which relationships can be strengthened and made more effective.

You could also do a second round of this exercise to determine what your aspirations are:

- You may want to add in missing partners.
- You may want to change relationships.
- You may want to remove relationships in order to simplify the landscape.

Doing this second round will help you to identify where action needs to be taken on partnership development.

Tool 2 – Assessing the Partnership

In this activity, partners answer a series of questions in a checklist describing the key features of a partnership. The checklist is designed to provide feedback on the current status of the partnership and/or suggest areas that need support and work.

The questions address the major issues of forming and sustaining meaningful partnerships.

There are three ways to complete the checklist:

1. The TSI can fill in the checklist and present the results to a meeting of the partnership. Canvassing the various partners' views at a meeting is a way of testing out the accuracy of the TSI's perceptions.
2. Each partner can be given a copy to complete independently. They can compare and discuss the results at a meeting. This approach ensures that the views of every partner are given equal weight.
3. The checklist can be completed as a group activity. This approach will tend to emphasise consensus among members.

The checklist creates a global score which accepts that there will be different perceptions.

Consequently, there is some value in including different examples that both confirm and test the overall result. For example, most partners may be working well but one or two may be seen to be less co-operative. The 'outliers' need to be considered but they should not skew the dominant response. Similarly, a partnership may rate well against some of the key features and not in others.

To use the checklists, follow the suggested approach:

1. Make copies of the checklist and, working as a group, consider each of the statements in relation to the partnership as a whole.
2. For each statement, rate the partnership on a scale, with a rating of zero indicating strong disagreement with the statement and a rating of four indicating strong agreement.
3. Look at the scores in each section, as this will show trends and illustrate areas of good practice as well as helping to identify aspects of the partnership in which further work needs to be done.
4. Consider aggregating the scores across the sections and using the accompanying key to establish an indication of the overall strength of the partnership. This will also provide a basis for monitoring aspects of the partnership over time. Aggregations are a gross measure, but can be good starting points for discussions about the project and the partnership.

Determining the need for the partnership					
	0 Strongly Disagree	1 Disagree	2 Not Sure	3 Agree	4 Strongly Agree
There is a perceived need for the partnership in terms of areas of common interest and complementary capacity.					
There is a clear goal for the partnership.					
There is a shared understanding of, and commitment to, this goal among all potential partners.					
The partners are willing to share some of their ideas, resources, influence and power to fulfil the goal.					
The perceived benefits outweigh the perceived costs.					
				TOTAL	

Choosing partners					
	0 Strongly Disagree	1 Disagree	2 Not Sure	3 Agree	4 Strongly Agree
The partners share common ideologies, interests and approaches.					
The partners see their core business as partially interdependent.					
There is a history of good relations between the partners.					
The coalition brings added prestige to the partners individually as well as collectively.					
There is enough variety among members to have a comprehensive understanding of the issues being addressed.					
				TOTAL	

Making the partnership work					
	0 Strongly Disagree	1 Disagree	2 Not Sure	3 Agree	4 Strongly Agree
The managers in each organisation support the partnership.					
Partners have the necessary skills for collaborative action.					
There are strategies to enhance the skills of the partnership through increasing the membership or workforce development.					
The roles, responsibilities and expectations of partners are clearly defined and understood by all other partners – including the ability to commit to action.					
The administrative, communication and decision-making structure of the partnership is as simple as possible.					
				TOTAL	

Planning collaborative action					
	0 Strongly Disagree	1 Disagree	2 Not Sure	3 Agree	4 Strongly Agree
All partners are involved in planning and setting priorities for collaborative action.					
Partners have the task of communicating and promoting the coalition in their own organisations.					
Some staff have roles that cross the traditional boundaries that exist between agencies in the partnership.					
The lines of communication, roles and expectations of partners are clear.					
There is a participatory decision-making system that is accountable, responsive and inclusive.					
				TOTAL	

Implementing collaborative action					
	0 Strongly Disagree	1 Disagree	2 Not Sure	3 Agree	4 Strongly Agree
Processes that are common across agencies, such as referral protocols, service standards, data collection and reporting mechanisms, have been standardised.					
There is an investment in the partnership of relevant resources - time, personnel, materials or facilities.					
Collaborative action by staff and reciprocity between agencies is rewarded by management.					
The action is adding value (rather than duplicating services) for the community, the clients, or the agencies involved in the partnership.					
There are opportunities for informal and voluntary contact between staff from the different agencies and other members of the partnership.					
				TOTAL	

Minimising the barriers to partnership					
	0	1	2	3	4
Differences in organisational priorities, goals and tasks have been identified and addressed.					
There is a core group of skilled and committed (in terms of the partnership) people that has continued over the life of the partnership.					
There are formal structures for sharing information and resolving demarcation disputes.					
There are informal ways of achieving this.					
There are strategies to ensure that alternative views are expressed within the partnership.					
				TOTAL	

Reflecting on and continuing the partnership					
	0 Strongly Disagree	1 Disagree	2 Not Sure	3 Agree	4 Strongly Agree
There are processes for recognising and celebrating collective achievements and/or individual contributions.					
The partnership can demonstrate or document the outcomes of its collective work.					
There is a clear need for and commitment to continuing the collaboration in the medium term.					
There are resources available from either internal or external sources to continue the partnership.					
There is a way of reviewing the range of partners and bringing in new members or removing some.					
				TOTAL	

Aggregating the score	
Determining the need for the partnership	
Choosing partners	
Making the partnership work	
Planning collaborative action	
Implementing collaborative action	
Minimising the barriers to partnership	
Reflecting on and continuing the partnership	
TOTAL	

Evaluating the Results

0–49: The whole idea of the partnership should be thoroughly examined and reconsidered.

50–91: The partnership is moving in the right direction but it will need more attention if it is going to be truly successful – try examining the areas with the lowest scores to identify areas for improvement.

92–140: A partnership based on genuine collaboration has been established. The challenge is to maintain its impetus and build on the current success.

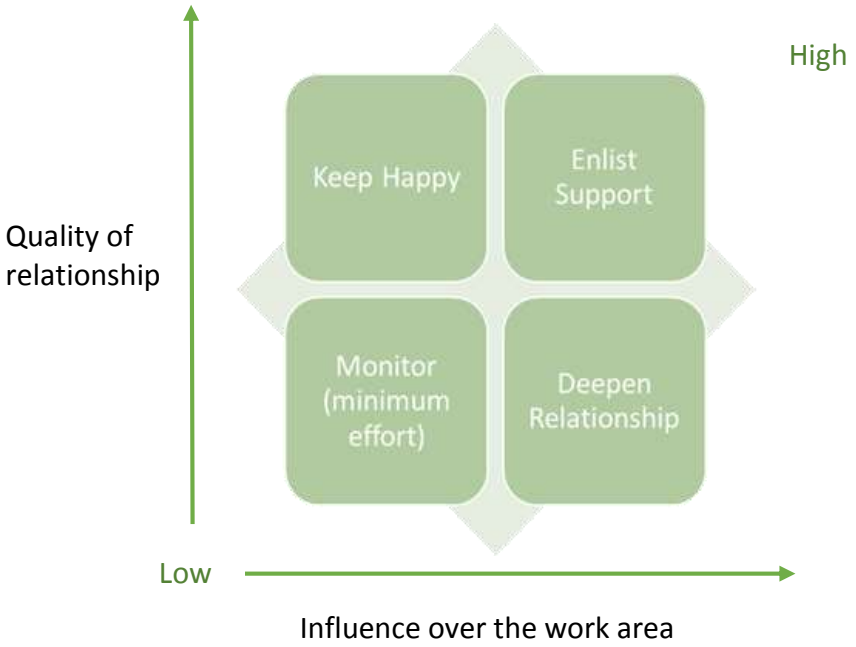
Once a map of stakeholders has been created, and an assessment made of how well partners are working within a partnership, the TSI may wish to focus on undertaking its own assessment of with which partners it would like to strengthen relationships, in order to increase or deepen their engagement with integration. Taking an approach such as this at various points throughout the life cycle of a partnership helps to focus efforts and update the direction of the TSI's work.

Tool 3 – Relationship and Influence

In tying together the partnership across the third sector to the partnership at Integrated Authority board level, you may wish to consider the types of relationships that the central connecting point currently has or would like to achieve between these two groups.

Considering the types of relationships you have with the partner organisations or would like to have, plot them on the grid below.

Relationship / Influence Grid



Once all the relevant stakeholders are included on the map, consider the following:

- If all the partners are clustered in a single area (regardless of which area that is), what needs to be achieved to move relationships to a more appropriate place on the grid?
- Are all the partners in the right place for the moment? If so, what efforts are needed to maintain those relationships?
- How are the relationships between the partners? Are there things that partners can do to strengthen these?

Tool 4 – Readiness Assessment

This tool is a checklist to be used to gain a sense of readiness for change. It can be used within an organisation or across a partnership. However you use it – whether informally with a handful of people or in an official all-hands-on survey – the Readiness Assessment will provide data to help prepare for a time of transition, to deal with it, and to measure how well you handled it when it has passed.

For each of the statements below, give a score of 0 to 4:

4 = the statement is definitely true or accurate.

3 = the statement is largely (though maybe not completely) true or accurate.

2 = the statement is only partly true or accurate.

1 = the statement is only occasionally (but not very often) true

0 = the statement is utterly false

		Score
1	Most people think that the change in question is a necessary one.	
2	Most people agree that, given the situation, the change represents the best way of dealing with it.	
3	The organisation's leaders have shown that they are committed to the change.	
4	In general, the middle managers are behind the change.	
5	So are the supervisors or first-line managers.	
6	The details of the change are being communicated to those who will be affected as quickly as it is practical to do so.	
7	There are effective ways for employees to feed back their concerns and questions about the change.	
8	… and those concerns and questions have, thus far, been responded to in a pretty honest and timely way.	
9	There aren't a lot of old scars or unresolved issues around here.	
10	The organisation has a history of handling change pretty well.	
11	The organisation's leadership has a history of doing what it says it will do.	

		Score
12	... and of saying what it is going to do before it does it.	
13	I think that, if this is what the leadership wants to do, they can pull it off successfully.	
14	Decisions generally get made in a timely fashion around here.	
15	When people get new roles or tasks, they can usually count on getting the training and coaching that they need to do them.	
16	When faced with new and challenging situations, the organisation forgets turf issues and gets problems solved.	
17	It is safe to take an 'intelligent' risk in this organisation; failure in a good cause or for a good reason isn't punished.	
18	There is a pretty widely understood vision of what the organisation is seeking to become and to accomplish.	
19	While the higher-ranking people obviously get paid more, we feel as though we're all in this thing together.	
20	People's commitment to their work here is as high as it was a year ago.	
21	Although the pace and extent of change around here is great, it is also workable.	
22	Management generally practises what it preaches.	
23	There is basically no argument about what the organisation's problems are around here.	
24	The organisation's leadership generally shows an awareness of and concern for how change will affect the rest of us.	
25	People generally understand how things will be different when the change is complete.	

TOTAL SCORE _____

Evaluating the Results

If a number of people are filling out this form, add the scores together question-by-question, so that you can say what the 'average' answer was on each item, as well as on the assessment as a whole. That way, you can identify weaker links in the partnership, as well as areas where things are pretty solid. It is useful to have an impersonal way to evaluate whether people think that the partnership has a vision of the future or not, or whether the leadership is trustworthy. These are charged subjects and it helps to be able to raise them in a way that doesn't assign blame.

It may also be useful to examine individual responses. This will highlight any difference of opinion and create the opportunity to discuss these and agree how to move forward.

In addition to giving you a sense of the partnership's strengths and weaknesses in terms of transition manageability, this exercise can also be used to measure:

- changes over time – before-and-after results – to measure the impact of an announcement, an intervention, a problem that arises, and a positive development that takes place;
- transition readiness in relation to different changes; and
- differences within an organisation, e.g. between two parts of the organisation or two different levels of the hierarchy.

Tool 5 – Readiness Assessment – Version 2

	0 Strongly Disagree	4 Disagree	3 Neither agree nor disagree	2 Agree	1 Strongly Agree
1. We have a clear and widely communicated vision					
2. We have identified positive incentives for change					
3. We don't have enough funds or resources to help with the changes					
4. We don't know what organisational competencies – skills, knowledge, abilities – we need					
5. Incentives for change don't target the right people					
6. We are unsure who our key stakeholders are					
7. We don't have a plan to fill any gaps in our organisational competencies					
8. Our action plan – with tasks and responsibilities – is not clear					
9. We know how the vision impacts on our key stakeholders					
10. We know what we are good at now					
11. We haven't really identified the stakeholders who need to be consulted for change					
12. We're aware of the emerging organisational competencies that we need to develop					
13. We have identified and communicated the negative consequences of not changing					
14. We have the right people on board to help with the change					
15. We are not effectively selling our vision to our key stakeholders					
16. We haven't explained the negative consequences of not changing					

17. Where there are funding or resource challenges, we don't have a plan to overcome them					
18. Everybody knows what they need to do to achieve the change.					
18. Where we don't have the right people to help with the changes, we are taking steps to fix this.					
19. We have an agreed action plan or have identified someone to create it.					

3. Improving Strategic Commissioning

One of the key aims of integration is to make improvements to services and approach things differently to achieve improved outcomes and system efficiencies – by changing the commissioning and procurement systems that are used to plan, commission and deliver the services. To achieve this, Integration Authorities will have to consider the mixture of approaches they wish to include within their local plans. This section takes a look at strategic commissioning – the key approach.

Strategic commissioning (or strategic 'planning' as it is referred to in the Public Bodies (Joint Working) (Scotland) Act 2014 (see Appendix A) is the key practical mechanism introduced by the Act to bring about the successful integration of health and social services. The purpose of strategic commissioning is to understand the needs, resources and supports in a local area and to use this data to plan the effective delivery of health and social care services that promote positive outcomes for people. The third sector has an important role in strategic planning – both as a sector that delivers services, and as a strategic partner bringing expertise and data to inform strategic plan development.

3.1 The Role of Strategic Commissioning in Integration

This introductory section explains the practical requirements of the Act and their relevance to the third sector, and provides some suggestions for engagement. As noted above, strategic commissioning is viewed by the Scottish Government as the principal mechanism by which integration partnerships will achieve the goal of improved outcomes for people. The Act therefore requires Integrated Joint Boards to produce a 'Strategic Plan' for the integrated functions and budgets that they control. The Strategic Plan must explain how these arrangements are going to contribute to achieving the National Health and Wellbeing Outcomes. And in developing the Strategic Plan, the Integrated Joint Board must 'have regard to' a series of integration principles set out in the Act, including the main purpose of integration: to improve the wellbeing of service-users. A helpful Guidance Note has been produced explaining each of the 12 integration principles and providing a checklist to help identify progress and challenge partners' effectiveness.

A copy of the Guidance Note is available here:
http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Implementation/working_Groups/Principles/PlanningandDeliveryPrinciples

3.1.1 Strategic Planning Group

The strategic commissioning process is intended to be a broadly inclusive, collaborative exercise, and each Integration Authority is required to establish a Strategic Planning Group to support the development of the Strategic Plan. Scottish Government guidance on how Integration Authorities should develop their Strategic Commissioning Plans emphasises the requirement for Integration Authorities to involve a range of groups, including the third

sector, in the commissioning process. To reinforce this point, it quotes the Christie Commission Report:[2]

> *"… effective services must be designed with and for people and communities – not delivered 'top down' for administrative convenience."*
> (p.ix)

Although the Integrated Joint Board determines the number of members and the process for the appointment, replacement and removal of members, the Strategic Planning Group must include members to represent the following interests:

- Users of health care.
- Carers of users of health care.
- Commercial providers of health care.
- Non-commercial providers of health care.
- Health professionals.
- Social care professionals.
- Users of social care.
- Carers of users of social care.
- Commercial providers of social care.
- Non-commercial providers of social care.
- Non-commercial providers of social housing.
- Third sector bodies carrying out activities related to health or social care.
- Any other person or persons that the Integration Authority considers appropriate.

The guidance also notes that at the heart of good strategic commissioning is the 'establishment of a mature relationship' between the different partners from across the sectors. As such, it endorses the importance of the full contribution to strategic commissioning and locality planning of the third sector's knowledge, expertise and information. TSIs are seen as playing a key role in facilitating that contribution. Section 2 of this handbook, **Defining the Role of the Third Sector and the TSI**, provides a range of suggestions to support the TSI's facilitation role in general, and there are further suggestions specific to strategic commissioning referenced below.

Broad engagement will require strong communications among all the participants in the strategic planning process. The Integration Authority is expected to develop a communications plan at an early stage, as well as publishing a description of the consultation process along with the final plan. *This is highlighted in the Strategic Commissioning Guidance:* http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Implementation/ImplementationGuidance/SCPlans

[2] Dr Campbell Christie, 'Commission on the Future Delivery of Public Services' (June 2011), online source available here: http://www.gov.scot/resource/doc/352649/0118638.pdf

Both TSIs and the wider third sector should consider the extent to which they are able to contribute to the communications plan in order to facilitate the broadest possible engagement in the planning process, as well as dissemination of the final plan and details of implementation. Procurement and Market Facilitation Plans included as part of the Strategic Commissioning Plan will be of particular interest to third sector organisations providing services in a local area (more on these below).

Engagement with stakeholders and the involvement of the Strategic Planning Group (or in some cases several groups, where an Integration Authority has established different thematic planning groups) is intended to be a continuous process, with the Strategic Planning Group reviewing progress on an ongoing basis during the life of the plan. The plan should be revised when necessary and must be reviewed at least every three years.

3.1.2 Measuring and Reporting How Plans Contribute to Better Outcomes

The Act requires the Integration Authorities to measure and report on the progress of integration in achieving the National Health and Wellbeing Outcomes.

A copy of the Outcomes is available here: http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes

The Integration Authority must prepare an annual performance report setting out how the Strategic Plan is achieving or contributing towards achieving these outcomes. There should be a clear recording and measurement framework so that both the Strategic Planning Group and the Integration Authority can assess whether agreed aims are being achieved. A series of indicators related to the National Health and Wellbeing Outcomes have been developed to support that measurement. They include both personal outcomes and organisational or systems outcomes, some of which are designed to evidence the shift in the balance of care from institutional settings to the community; towards support for preventative and anticipatory care.

A copy of the Indicators is available here: http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes/Indicators

3.1.3 Scrutiny

The Act also introduces a new remit for the Care Inspectorate and Healthcare Improvement Scotland to jointly inspect the extent to which both services and the strategic planning process contribute to achieving the national outcomes. The third sector should be involved in the inspection process both as providers of relevant services, as participants in the strategic planning process, and as a source of information about the impact on communities of the services provided under the Strategic Plan. TSIs are likely to have a role to play in facilitating that involvement, through existing – or newly developed – third sector forums and through participation in the Integration Authority and Strategic Planning Groups.

The remainder of this section looks at the issues and challenges for third sector service providers in relation to commissioning and procurement; general principles of good strategic commissioning; the relationship of strategic planning with procurement; and the common barriers experienced by the third sector. It also provides some suggested alternatives to current practice.

3.2 Third Sector Health and Social Care Provider Issues

As noted above, for strategic commissioning to work well, there needs to be a 'mature relationship' between the partners; and, we would add, a relationship of trust and equality. This level of engagement presents both challenges and opportunities for the third sector, and health and social care providers ('third sector providers') in particular. There are a number of factors that need to be recognised and explored in the context of developing third sector capacity to engage with strategic commissioning. This section sets out the particular issues for third sector providers, who will play an important part in strategic planning as significant providers of commissioned services.

3.2.1 Procurement, Austerity and Funding Cuts

In general, most third sector providers are not involved in planning and service design but are brought into the commissioning process at the procurement stage, often involving a form of competitive tendering. The predominant use of competitive tendering as a procurement mechanism in social care services has resulted in a focus on hourly rates for care rather than on positive outcomes for service-users.

The impact of procurement reform, including the rise of competitive tendering, and budget cuts associated with the recession and austerity, have led to a significant decrease in hourly rates for care and support over the past several years. Given that up to 85% of third sector provider expenditure relates to workforce costs, it is clear that sources for further efficiencies in the delivery of support are limited, and further stripping out of managerial and oversight structures may result in compromised quality. [3]

The current Scottish Government focus on 'fair work' (including the living wage), while supported by third sector providers and the third sector more generally, raises significant challenges for third sector providers. Given the tight financial margins within which they operate, payment of the living wage is contingent on the contracting authority's setting of a fair hourly rate and an adequate contract value. A recent tender for social care support capped the hourly rate at a level too low to allow the payment of the living wage and yet included 'fair work' as a tender criterion.

Fair work practices also discourage the use of 'inappropriate' zero hours contracts but fail to recognise the structural context that leads to the use of these contracts. At the macro level this includes the increasing use of framework contracts, an organisational-level zero hours contract where no work is guaranteed to the supplier. At a workforce level there is also the

[3]Cunningham. I and Nickson, D (2012), 'Public sector austerity, personalisation and the implications for the voluntary sector workforce University of Strathclyde/P&P': http://www.ccpscotland.org/pp/resources/public-sector-austerity-personalisation-implications-voluntary-sector-workforce-2012/

increased personalisation of support under Self-Directed Support, which may require more flexible and fragmented working hours from the workforce.[4]

Continued downward pressure on hourly rates has led to an erosion of salary, terms and conditions among third sector providers. The flattening of management structures reduces career progression for workers. These factors combine to make recruitment and retention in the sector very challenging. Public sector provision often retains more favourable terms and conditions, and this can lead to workforce 'drain', with third sector providers training and developing new workers, only for them to move on to public sector roles once qualified and/or experienced.

In connection with workforce issues, the Integration Authority is required to prepare a workforce development and support plan as part of its strategic planning process. Because of the significant amount of social care services provided by the third sector (as much as 35–40% of social care services depending on the area), the integration partnership should include the wider workforce in this plan. This emphasis on workforce development follows from the Scottish Government's 'four pillars' response to the Christie Commission recommendations, one of which is:

> *"greater investment in the people who deliver services through enhanced workforce development and effective leadership"*

3.2.2 Level Playing Field

Because only services provided by the third and private sectors are subject to procurement via competitive tendering, this creates an unequal playing field for third sector providers. Many councils operate an 'in-house first' strategy without fully understanding the actual cost of in-house provision. External providers are subject to a high degree of (sometimes duplicatory) oversight, including both contract monitoring and external scrutiny from regulators.

External providers must also grapple with an environment that heightens the risk of business instability with the award of one-year contracts; the increasing use of framework agreements (where no work is guaranteed); and the operation of resource clawback for third sector providers in particular (where any surpluses remaining at the end of a contract term must be returned to the commissioning authority despite full delivery of contract requirements, thus discouraging efficiency savings and often jeopardising accepted reserves policies). Despite these challenges, third sector social care providers regularly obtain higher Care Inspectorate quality grades than their public or private sector counterparts. The concern is that this will not be sustainable in an environment of indiscriminate cost-cutting.

3.2.3 Impact on Service-Users

Competitive re-tendering is destabilising to service-users. It is acknowledged that continuity is a key feature of good-quality care, and, in particular, the quality of relationships between

[4] Cunningham and Nickson (2012)

people is key to achieving positive outcomes. This principle is recognised in the 2014 EU procurement directive, which states that public authorities may consider issues of continuity and sustainability in contract-award for social care[5] (more on this below). It is also against the Self-Directed Support principles of choice and control, because it is the authority, rather than the service-user, that exercises choice in the market.

3.2.4 Multiple Interests and Roles

Many organisations engaged by the Integration Authority may fulfil multiple roles. Some TSIs are service-providers themselves; some service-providers offer brokerage or direct payment services, and many local authorities have a range of roles: commissioner, purchaser, service-provider, assessor and budget-setter. In some areas, there is a history of competition between providers and between large national providers and smaller local organisations. All organisations need to be aware of their multiple interests and clear on the role they are taking on – that of strategic partner and advocate for specific interests – within the partnership generally, and especially within the Strategic and Locality Planning Groups. All organisations in the partnership should be sensitive to the fact that multiple interests do not, of themselves, lead to irreconcilable conflicts of interest.

3.2.5 Relationships and Collaboration

The range of issues detailed above presents some significant challenges for the third sector to work in true collaboration and to build effective working relationships. Collaborative working is challenging where:

- there are significant power differentials between the sectors and/or partners;
- there has been a historically unequal approach to service purchase and funding levels (the in-house/external split);
- competitive approaches have led to a degree of mistrust and a reluctance to share good practice.

That said, there are examples of highly effective collaborations and partnership working, both between third sector organisations and between the third and statutory sectors. Transparency, clarity of roles and accountability, and building relationships of trust, are fundamental to their success.

Third sector providers and the wider sector have a tremendous amount of experience, expertise and important information to contribute to the strategic commissioning process.

Mobilising this is the task. One place to begin, in keeping with the wider procurement reform policy agenda, will be to challenge the 'competition is best' orthodoxy. There are a number of recent initiatives that explore alternatives to competitive tendering (more on this below).

[5] Directive 2014/24/EU on public procurement and repealing Directive 2004/18/EC article 76 (2): http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex:32014L0024

3.3 What Strategic Commissioning Is

[Joint] strategic commissioning is:

> *"the term used for all the activities involved in assessing and forecasting needs; linking investment to agreed outcomes; considering options; planning the nature, range and quality of future services; and working in partnership to put these in place."*
>
> (National Steering Group for Joint Strategic Commissioning, 2012)

Strategic commissioning is the mechanism via which the new Integration Authorities will deliver better care and support for people, and make better use of the resources invested in health and social care to achieve improved outcomes for people who need health or social care support.

The **Strategic Commissioning Cycle: Analyse, Plan, Do and Review** is now well established, and accepted by partnerships across the country. However, for this approach to work effectively it must be underpinned by the development of effective working relationships between public authorities, providers, supported people and their representatives.

Stage	Focus	How the third sector contributes
Analyse	How many people need services and what type of support is needed. What is currently provided and whether this is at the right level, quality and cost. The financial position of the public authorities and the resources available.	Knowledge of the range of third sector services and types of provision in the locality. An understanding of how different services dynamically interact around individuals and/or in communities. Learning from direct service provision about 'what works, for whom and in what way'. Data about what choices people who use services are making.
Plan	Develop a Strategic Plan. Set outcomes and link in proposed activities and inputs (resources). Clearly articulate how investment/ disinvestment decisions are being made. Analyse service gaps.	Ways of developing the capacity of people who use services to directly contribute to the planning process. Information on how community capacity and resilience is changing. Opportunities for the voice of service-users and communities to be heard – either through data collected by third sector organisations or by developing their capacity to contribute directly. Ideas about creative and innovative ways of delivering support that is person-centred.
Do	Service is purchased and delivered. This stage links closely with the public authority's approach to procurement (see Section 3.4 below)	Delivery of good-quality services
Review	How the commissioning plan will be monitored and reviewed to check whether it is leading to improved outcomes for supported people.	In the cycle, the 'Review' stage is an opportunity to assess whether services and support have worked for individuals and communities. Third sector data can be triangulated with public sector and national data, which provides a useful way of checking the impact of the commissioning strategy in each integration area.

Tools

The three-step improvement framework for Scotland's public services provides a helpful way of thinking about how partnerships can work together to create the conditions for improvement in service delivery. See: http://www.gov.scot/Resource/0042/00426552.pdf

The TLAP/IPC guide to market facilitation gives helpful ideas and support on partnership working in commissioning. http://ipc.brookes.ac.uk/services/documents/Market_Shaping_Toolkit.pdf

NES/SSSC have launched an online training resource for strategic commissioning at: http://learn.sssc.uk.com/strategiccommissioning

3.4 Relationship with Procurement

Strategic commissioning is, in essence, the plotting of the provision of a wide range of services and types of support against the needs and preferences of a local population. Procurement is the major way in which these services are selected and purchased by the public authority. A Strategic Plan should drive the approach that a public authority takes to procurement, with both processes focused on how to promote improved outcomes for supported people.

As noted above, recent changes to EU and Scottish legislation[6] recognise that social care procurement differs from the procurement of other goods and services, as social care is based on relationships, making *continuity*, *quality* and *sustainability* imperative to the delivery of excellent care and support to vulnerable people.

Public sector procurements must still adhere to the EU treaty principles of transparency, equal treatment and non-discrimination. However, as a result of the 2014 EU directive, public bodies may also take into account other issues when procuring social care services such as quality, continuity and availability. [7]

The major change for health and social care is to free up public authorities from the **requirement** to competitively tender for social care services between the value of €50,000 and €750,000. Public authorities can award without tendering (if they are assured they are not breaching the EU treaty principles in doing so). For contracts over €750,000 there is a requirement to advertise in the OJEU (the European Journal in which higher-value contracts are advertised). The procurement process for this is described as 'light-touch'. Contracts of a value below €50,000 are 'unregulated' and do not fall within the scope of the Act. Public authorities are also required to produce a procurement strategy for any spending that exceeds £5 million in any calendar year. The procurement strategy can provide a useful source of information to feed back into the commissioning cycle.

[6] s.12 of the Procurement Reform (Scotland) Act, 2014: http://www.legislation.gov.uk/asp/2014/12/contents
[7] Directive 2014/24/EU on public procurement and repealing Directive 2004/18/EC article 76 (2): http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex:32014L0024

Statutory guidance is being produced to support the implementation of these pieces of legislation. This new guidance includes a full review of the 2010 Procurement of Care and Support Guidance:
http://www.gov.scot/Topics/Government/Procurement/policy/SocialCareProcurement

The new guidance will be published on the Scottish Procurement Directorate website:
http://www.gov.scot/Topics/Government/Procurement

3.5 Barriers to Good Strategic Commissioning

Reference was made in **Section 1** to the ALLIANCE, CCPS and VAS dialogue event that sought to explore the opportunities and barriers to strategic commissioning faced by the third sector. These included:

- **Relational barriers**: such as lack of trust between partners.
- **Funding and tendering barriers**: such as competition, competitive tendering and fear of not surviving as an organisation.
- **Practical barriers:** lack of resourcing to participate, concern about how the varied sector can be effectively represented.
- **Motivational/emotional barriers**: such as cynicism – the feeling that 'nothing changes' – and fear of change.

There are other challenges to good strategic commissioning in local areas despite the wide acceptance of the strategic commissioning cycle as the model of choice. The 2012 Audit Scotland report into social care commissioning in Scotland found that:[8]

- providers are not sufficiently involved in social care commissioning;
- sufficient attention is not given to the financial and 'market' factors that can lead to provider closure;
- there needs to be improved use of data and information on needs, preference, outcomes and quality.

The third sector can support the improvement of commissioning in the areas identified by the 2012 report. It can:

- draw on and share its knowledge, connections and data to provide information to improve the analysis phase of the cycle;
- work strategically with the partnership to bring the views, expertise, learning and innovation from the sector to the table; the third sector has significant reach into excluded communities and can help by offering engagement, consultation and co-production with these groups; and
- provide critical feedback on the effectiveness of the Strategic Commissioning Plan overall to check that (1) people are getting the support they need to meet their outcomes, and (2) the commissioning plan is working in providing a range and diversity of providers and types of support.

[8] Audit Scotland (2012), 'Commissioning Social Care': http://www.audit-scotland.gov.uk/docs/health/2012/nr_120301_social_care.pdf

Tools

Asset mapping (IRISS): http://www.iriss.org.uk/resources/using-assets-approach-positive-mental-health-and-well-being

Using evidence to demonstrate success (Evaluation Support Scotland): http://www.evaluationsupportscotland.org.uk/our-work-partners/knowledge-translation-network/evidence-success-guide/

3.6 Enabling Good Commissioning: Approaches and Tools

Strategic commissioning in the context of integration is a complex activity involving a range of different organisations and people, many which may have competing interests and contrasting working and relational styles.

There are a number of collaborative approaches to commissioning and procurement available for contracting authorities to consider. These approaches may be fully collaborative across the strategic commissioning and procurement cycle, or can maximise collaboration, innovation and relationship-building in the phase before a procurement process if this is deemed necessary by the contracting authority. Examples of collaborative alternatives include alliance contracting and Public Social Partnerships.

3.6.1 Alliance Contracting

Alliance contracts originate in the oil and gas industry and are an arrangement where a number of parties enter into an agreement to work co-operatively and share risk and reward. The success of the contract is measured against outcome indicators agreed by the collaboration. The contract supporting the partnership looks to align the interests of all the partners with the project's aim.

In this approach, the public authority acts as both a commissioner and delivery partner, creating an integrated cross-sector team.

Alliance contracts are often facilitated by an external, neutral facilitator and are most successful when built on existing good relationships and collaboration.

This approach can be used both within a procured process (i.e. where the public authority invites consortia bids) or within a non-competitive process.

Example

The Lambeth collaborative is an informative example of how alliance contracting, alongside user co-design; effective data collection and analysis; and a focus on relationship building led to positive change in the delivery of mental health services: http://lambethcollaborative.org.uk/what-is-the-collaborative.

3.6.2 Public Social Partnerships

The organisation Ready for Business defines Public Social Partnerships (PSPs) as "strategic partnering arrangements, based on a co-planning approach, through which the public sector can connect with third sector organisations (voluntary, charity and social enterprise organisations) to share responsibility for designing services based around service-user needs". In common with alliance contracting, this is a collaborative approach and is most successful where the work is built on existing good relationships and collaboration.

3.6.3 Key Questions for Partnership Meetings

Before the meeting

1. Do you understand the history of the relationships in the room?
2. Do you have a good understanding of the organisational culture, priorities, risks and approach of all the partners in the process?
3. Are you clear on how/whether every partner is resourced to participate?

At the first meeting

4. Does everyone have a shared vision/purpose?
5. Is everyone clear on their roles?
6. Have you openly discussed the multiple interests of **all** partners?
7. Do you have agreement on how partners should behave when the discussion gets difficult?

Throughout the process

8. Are your meetings well structured, purposeful and kept to time and task?
9. Are you sensitive to times when organisational cultures or professional identities are causing clashes?
10. Do you have agreement on how partners should behave when the discussion gets difficult?

Tools

From Providers to Partners: what will it take?
http://www.ccpscotland.org/resources/providers-partners-will-take/

Commissioning for Outcomes and Co-Production
http://www.neweconomics.org/publications/entry/commissioning-for-outcomes-co-production

D cards: difficulties, deliberations and discussions (IRISS/P&P)
http://www.iriss.org.uk/resources/d-cards

"Change without Migraines" (Rick Maurer)
http://www.changewithoutmigraines.com/OpenSourceProject.htm

3.6.4 Tools to Support Working Together

A facilitative approach to commissioning draws together relevant groups, organisations and people to develop relevant commissioning plans for a local area. A facilitative approach supports co-production and can encourage wider use of data and information from the third sector, as well as modelling positive partnership behaviours in the process.

TSIs should support partnerships to explore the potential for innovation. Design and improvement methodologies can be used to influence the direction of the Strategic Plan and provide processes for challenging current service design and planning.

These methodologies include:

Method	Focus	About	Example
Facilitation	Developing relationships; defining group purpose; having challenging conversations.	http://www.kinharvie.org.uk/organisation_development/facilitation-1	http://www.kinharvie.org.uk/case-studies-1/case-study-2
Innovation/ Creativity	New ideas and novel approaches to existing problems.	http://cq.iriss.org.uk	https://www.casseroleclub.com
Prototyping and failure	A subset of design-led processes – prototyping encourages fast development, fast failure and fast (re)development.	http://www.iriss.org.uk/resources/iriss-failure	http://www.goodfornothing.com
Design-led	A range of approaches to encourage critical appraisal and the changing of existing approaches or models; or to create new models from scratch, e.g. developing a new mental health service.	www.99U.com	http://pilotlight.iriss.org.uk/co-design
Quality improvement	Structured, incremental changes to improving existing processes, e.g. streamlining referral paperwork.	www.qihub.scot.nhs.uk	http://www.people2peoplecic.org.uk

3.7 Investing in Partnerships

Working in partnerships that embrace approaches towards improving strategic commissioning requires all involved to take on and establish new ways of working and to create a culture of critical examination in order to achieve improvements to outcomes. Understanding the role of partnership approaches and positive collaboration in tackling the barriers that are likely to be faced requires the Integrated Joint Board to take a view on how it will approach this.

To assist the Integrated Joint Board to reach this position, there needs to be clarity about the range of knowledge, skills and competencies that each partner can bring and how they will need to be supported to fully engage with the approaches taken by the Board. Regular and consistent investment by the Integrated Joint Board in partnership skills and facilitative techniques to improve strategic commissioning – for all partners involved – will be a crucial contributing factor to success.

4. Gathering and Using Data

The use of data is a key tool in identifying trends in service use, assessing inequalities and projecting future needs. This section provides an overview to gathering and using data to inform decision-making within integration. It highlights some of the key principles of gathering primary data so that TSIs and the wider Integration Authority can monitor and evaluate specific interventions. It also contains links to external sources of data and evidence that may help to inform the local development of priorities, service-design and the allocation of funding.

4.1 Introduction

As mentioned throughout this handbook, the use of good-quality data is becoming increasingly important and will be a core aspect of changing strategic commissioning. Because of this, it is essential that third sector organisations:

- understand what data is being gathered and used, and how it is used;
- are able to collaborate and use their data and intelligence to create a broader third sector view; and
- are able to contribute this third sector view to the strategic commissioning process.

In order to achieve these aims, the TSI, as part of its partnership broker role, will have a significant part to play in building capacity across the sector to gather and use data and intelligence. Doing so will enable the third sector to:

- identify specific priorities in their area;
- compare their area with others across Scotland;
- ensure that any interventions have an evidenced need; and
- monitor the progress of new services against baseline figures.

The TSI specifically, and the third sector more generally, will need to be aware of the range of data being provided to Integration Authorities and be clear about how that data is collected, analysed and used in decision-making.

This data will consist of both new and existing evidence and is likely to be a shared responsibility across the Integrated Joint Board.

The figure below (Figure 1) shows the cycle of how good-quality evidence can be gathered and used to influence the decision-making process.

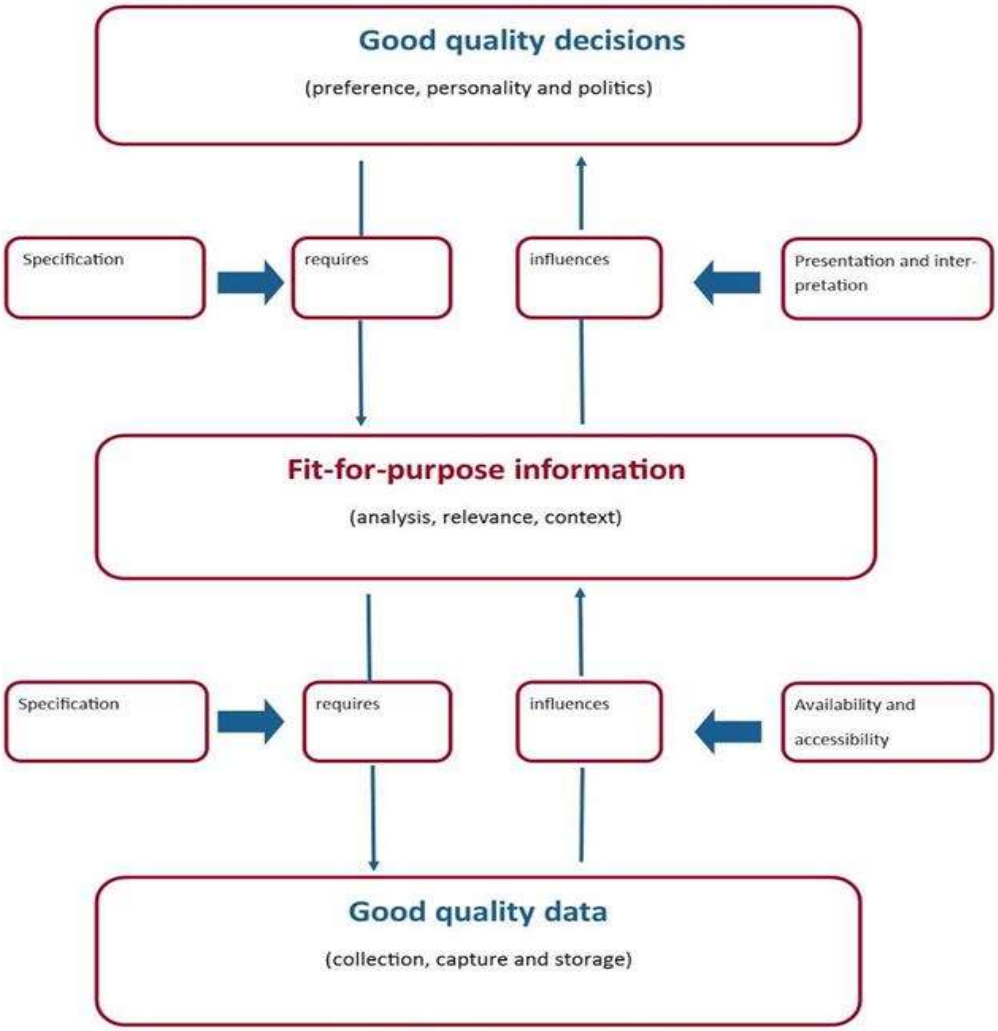


Figure 1 – Stages in Producing and Using Information (Audit Commission)

4.2 Challenges in Data Management

There are several significant challenges in collecting and managing data. Some of these are detailed below.

4.2.1 Who Does What?

One of the challenges of working in a complex partnership such as this is uncertainty about who is responsible for collating different types of evidence and reporting on each area. It is recommended that this be clarified as early in the process as possible.

Note: This applies to both the Integration Authority and to any health and social care third sector network.

It will be important that each partner knows:

- what they are collating;
- what the other partners are collating;
- how this information will be monitored; and
- how the information will be used.

Putting these governance policies in place from the start will ensure the data collected is both relevant and effective. It will also help to avoid duplication in activities and identify gaps emerging in the partners' knowledge.

Each of the partners will have existing skills and strengths in certain areas, e.g. while the Health Board may have the existing databases for securely storing and managing quantitative patient data, the TSI or wider third sector may have more experience in gathering and analysing qualitative data such as interviews and personal outcome-tracking. It is recommended that these different strengths are recognised and utilised to ensure effective and coherent data-collection and -management.

Some questions to consider include:

- How can relevant information be accessed by those who need it? For example, will there be a shared electronic filing system for the partners? Who should the partners contact if they have a data query? Who will keep the relevant contact details up-to-date?
- Who is responsible for collating the baseline figures and ensuring that the information is kept up-to-date?
- How often will data be reviewed and how will this be achieved?
- Who are the stakeholders and what do they need the information for? For example, the Scottish Government will use parts of it to monitor progress, while front-line staff may use it to improve existing services.
- How will information be shared with appropriate networks, organisations, services and individuals?

When gathering and storing data, care must be taken to comply with ethical considerations and data protection guidelines. More information on these can be found here:

Further Information

Data protection policy: http://www.gov.scot/About/Review/kerelaw/About/Review/data-protection

Ethics in social research: http://www.socialresearchmethods.net/kb/ethics.php

4.2.2 Too Much Data

There is a range of evidence available to the public on health and social care (*some of the possible sources for this are included at the end of this section*). This includes figures for delayed discharge, national inpatient surveys and area profiles. Whilst certain elements will be of use to you, it is important to acknowledge that a TSI cannot count everything. Nor should it. It is up to each health and social care third sector network to decide what its priorities are and how it will monitor progress and what information is needed to achieve this.

Integration Authorities will have their data needs defined by the collection of data on nationally set indicators and will then identify any additional local priorities and define how and what to measure, in order to demonstrate progress on meeting those.

It is recommended that this process be completed as early as possible; however, there should also be regular reviews. This will ensure that the information being collated is relevant, meeting the objectives of supporting the partnership in decision-making, and informing improved and integrated health and social care.

4.2.3 What Is Good Data?

There is a traditional hierarchy of data, with randomised control trials (RCTs) viewed as the 'gold standard' of data collection. This is shown in Figure 2, overleaf.

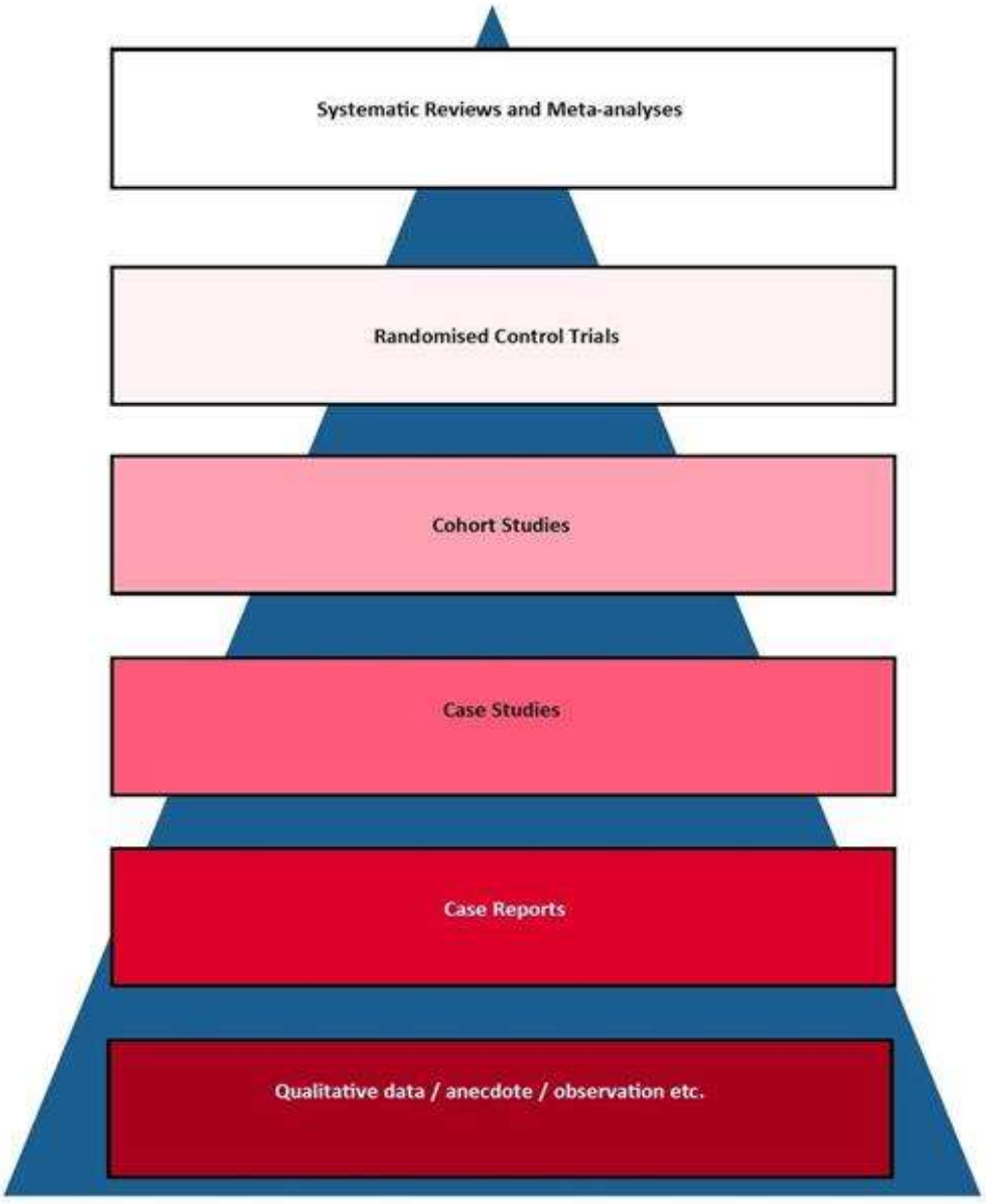


Figure 2 – Hierarchy of Evidence

Whilst different sources may have nuanced variations within this framework, it is generally accepted within health care that the more controlled a study, the more believable the results. This is because controlled studies are systematic in their approach, reduce the likelihood of bias influencing the results, and acknowledge and reduce the number of variables within the study.

As a result, qualitative data such as anecdote, personal outcomes-measurement, storytelling and observation are usually placed at the bottom of the hierarchy, with less credence being given to their findings. This can be problematic for the third sector, where randomised control trials are not prevalent. This is due in part to limited resources and in part because they are not considered to be necessary to demonstrate the impact of most third sector activities. Indeed, some believe that using a traditional hierarchy of evidence is unhelpful and that instead we should use a matrix (Figure 3) to consider different ways of gathering data.

A Matrix of Evidence to Address Various Aspects of the Question: 'Does This Work?'								
Research question	**Qualitative research**	**Survey**	**Case-control studies**	**Cohort studies**	**RCTs**	**Quasi-experimental studies**	**Non-experimental studies**	**Systematic reviews**
Does doing this work better than doing that?				*	**	*		***
How does it work?	**	*					*	***
Does it matter?	**	**						***
Will it do more harm than good?	*		*	*	**	*	*	***
Will service-users be willing to or want to take up the service offered?	**	*			*	*	*	***
Is it worth buying this service?					**			***
Is it the right service for these people?	**	**						**
Are users, providers, and other stakeholders satisfied with the service?	**	**	*	*				*

Figure 3 – 'What Makes Good Evidence' Matrix [9]

As the matrix above suggests, RCTs are only appropriate for answering about half of the research questions that are being addressed. Also, it is not the only appropriate tool for gathering data for any of the research questions being asked. With this in mind, it is clear

[9] Adapted from Petticrew and Roberts 2003, Table 1, p.528, also available online in Sandra Nutley, Alison Powell and Huw Davis, 'What Counts as Good Evidence: Provocation Paper for the Alliance for Useful Evidence', Alliance for Useful Evidence (February 2013) p.13: http://www.alliance4usefulevidence.org/assets/What-Counts-as-Good-Evidence-WEB.pdf (last accessed 28/09/15)

that each of the partnerships will need to use a range of methodologies and evidence to influence its decision-making and to monitor its ongoing progress.

One of the roles for the TSI may be to promote and advocate for different types of evidence to be used by the partners so that they can get a much more detailed and layered understanding of the issues they are dealing with. The use of different types of evidence will enable those organising the commissioning to take a more refined approach to what is needed.

The TSI can also support third sector organisations to ensure that there are robust methodologies for gathering, analysing and evaluating data. While qualitative data may be at the bottom of the hierarchy of evidence, this does not necessarily mean that it is of poor quality or of low value in decision-making. The Audit Commission asserts that 'good data' will comply with six characteristics; these are detailed in the table overleaf (Figure 4). As long as all information collected – whether qualitative or quantitative – complies with these principles, it should be considered by all of the partners throughout the decision-making process.

The Six Key Characteristics of Good-Quality Data	
ACCURACY	Data should be sufficiently accurate for its intended purposes, representing clearly and in sufficient detail the interaction provided at the point of activity. It should be captured only once, although it may have multiple uses. Accuracy is most likely to be secured if it is captured as close to the point of activity as possible. Reported information that is based on accurate data provides a fair picture of performance and should enable informed decision-making at all levels. The need for accuracy must be balanced with the importance of the uses of the data and the costs and efforts of collection. For example, it may be appropriate to accept some degree of inaccuracy where timeliness is important. Where compromises have to be made on accuracy, the resulting limitations of the data should be made clear to its users.
VALIDITY	Data should be recorded and used in compliance with relevant requirements, including the correct application of any rules or definitions. This will ensure consistency between periods and with similar organisations. Where proxy data is used to compensate for an absence of actual data, organisations must consider how well this data is able to satisfy the intended purpose.
RELIABILITY	Data should reflect stable and consistent data-collection processes across collection points and over time, whether using manual or computer-based systems, or a combination of these. Managers and stakeholders should feel confident that progress towards performance targets reflects real changes rather than variations in data collection approaches or methods.
TIMELINESS	Data should be captured as quickly as possible after the event or activity and must be available for intended use within a reasonable time period. Data must be available quickly and frequently enough to support information needs and to influence the appropriate level of service or management decisions.
RELEVANCE	Data captured should be relevant to the purposes for which it is used. This entails periodic review of requirements to reflect changing needs. It may be necessary to capture data at the point of activity which is relevant only for other purposes, rather than for the current intervention. Quality assurance and feedback processes are needed to ensure the quality of such data.
COMPLETENESS	Data requirements should be clearly specified based on the information needs of the organisation, and data-collection processes matched to these requirements. Monitoring missing, incomplete or invalid records can provide an indication of data quality and can also point to problems in the recording of certain data items.

Figure 4 – The Six Characteristics of Good-Quality Data[10]

[10] Audit Commission: http://archive.audit/-commission.gov.uk/auditcommission/subwebs/publications/studies/studyPDF/NEW1051.pdf (last accessed 15/08/15)

Note: It is recommended that the methodologies for collecting data be clearly detailed and made available to stakeholders on request. This will ensure that the process for evaluation and monitoring is transparent and the evidence robust.

4.2.4 National vs. Personal Outcomes

The Scottish Government's vision for health and social care is that it will improve outcomes for people living in Scotland. To achieve this, it is asserted that people must be at the heart of the services which affect them: that they are listened to, and are actively involved in deciding what care they receive and how it is delivered.

Each Integration Authority will be required to publish an annual performance report which will set out how they are improving the National Health and Wellbeing Outcomes. These reports must include information about the core suite of indicators that have been developed in consultation with COSLA, NHS Scotland and the third and independent sectors. *More information on these is available at:*
http://www.gov.scot/Resource/0047/00473516.pdf

The person-centred approach of integration is included within the national outcomes and indicators that have been developed by the Scottish Government – it is understood that these will be further developed over time.

4.3 Useful Sources

There is already a range of information available to the public regarding health care and social care services. This relates to both the outcomes being met and the quality of the services. TSIs can use this to inform their own work within health and social care integration. Nonetheless it should be noted that are still some gaps in health and social care data, particularly at a national level. Work is under way to fill some of these gaps and so new sources of data are likely to be available from 2015/16 onwards.

4.3.1 The Integration and Intelligence Project

The Information Services Division of NHS National Services Scotland has developed an Integration and Intelligence Project that maximises the use of health and social care data to provide a clear understanding of the whole patient/service-user pathway. The data needs to support effective decision-making, and prioritisation at all levels is being developed.

The Information Services Division aims to link health and social care data at an individual level to build an understanding of how people use services, particularly in terms of patterns of use. Working with local partners across health and social care, ISD will develop and deliver:

- a nationally agreed core dataset and definitions, which will enhance and build upon social care data already collected by the Scottish Government, the Care Inspectorate and other partners. This will include the annual Scottish Government Social Care Data Collection, the Scottish Care Home Census, and the Integrated Resource Framework (IRF) mapping exercise;

- a secure transfer of social care data from local authorities that is seeded with an individual's Community Health Index (CHI) number so that the CHI number can be routinely linked to existing national data sources with derived activity and costs;
- an IT solution to allow access to the data, with appropriate information governance safeguards;
- a reporting tool that will allow easy analysis and presentation of the data. This will provide a 'dashboard' for use on each area. It will be important for each health and social care third sector network to ensure that data from third sector organisations is included in this dashboard ; and
- bespoke analytical support and assistance with data interpretation

More information on the Integration and Intelligence Project can be accessed here: http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Health-and-Social-Care-Integration/

The project has provided A Guide to Data to Support Health and Social Care Partnerships in Joint Strategic Commissioning and Joint Strategic Needs Analysis. This is available here: http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/docs/Guide-to-Data-to-Support-HSCPs-8Oct2014-FINAL.pdf

4.3.2 MILO

MILO is an online database, knowledge management and reporting platform which is currently being used across the TSI network. It is anticipated that this may enable TSIs to gather, store and analyse relevant information on their wider third sector.

4.3.3 ALISS

The project *A Local Information System for Scotland* is gathering information from across public and third sector agencies and then providing that to all. This is done via a map so that people can search in specific postcode areas for a variety of formal and informal support.

Mapping the ALISS data and contrasting it with the data and intelligence from the third sector and the local priorities for prevention, reducing inequalities and service planning will be a useful way of highlighting gaps in provision and the targeting of future resources.

The link to the ALISS website is: https://www.aliss.org/

4.3.4 Public Health Information for Scotland (ScotPHO)'s Online Profile Tools

The Scottish Public Health Observatory (ScotPHO) has produced a publicly available 'Online Profiles Tool' which will enable partnerships to explore how health in their local authority compares to others. By providing a broad picture of health in Scotland, it aims to enable resources to be appropriately targeted to reduce inequalities.

The profiles and overview reports can be accessed here: http://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool

4.3.5 Understanding Scottish Places (USP)

'Understanding Scottish Places' (USP) has been developed by a consortium of organisations: Carnegie UK Trust; Scotland's Towns Partnership; the Centre for Local Economic Strategies (CLES); and the University of Stirling. It brings together data about places and people in Scotland into one visual and searchable database and provides an insight into the facts, figures and interrelationships that underpin all of Scotland's towns and cities. As well as containing information about towns with a population of over 1,000 people, it also offers potential comparators by highlighting areas that have similar data. This will allow the Integration Authorities to develop a greater understanding of their own area(s) but to also potentially learn lessons from other areas.

The website can be accessed here: http://www.usp.scot/

4.3.6 Other Sources

The table overleaf contains links to a number of other useful national sources which may help TSIs and their wider integration authorities to identify appropriate evidence to influence and support their decision-making process. It also shows which sources might help to measure outcomes or services.

Each level of data will work in tandem to create a comprehensive picture of the needs and assets within each area, as well as highlighting which interventions are the most effective.

	Measuring Outcomes	Measuring Quality (service)	Regulatory and Inspection
National (health)	**National Indicators** Source: http://www.gov.scot/Resource/0047/00473516.pdf Comments: The Scottish Government, in consultation with others, has produced a set of national indicators. The Integrated Joint Boards will all be required to report against these annually so that the ongoing progress of integration can be monitored.	**National Patient Survey** Results can be localised. Source: http://www.gov.scot/Topics/Statistics/Browse/Health/InpatientSurvey Comments: This is a biennial survey which can be searched at a national level and by each health board. It does not include all of the information. **Other** There are also other data sets, some of which are currently being developed, including figures on delayed discharge, the NHS Continuing Care Census and workforce information. Links for these and others can be found on the ISD website as detailed on the previous page.	**Audit Scotland** **Care Commission** **Individual professions** also have standards and competency frameworks required for registration, e.g. Royal College of GPs, Royal College of Nursing, Scottish Social Services Council.
National (social care)	This is the same as above.	**Scottish Social Care Survey** Source: http://www.gov.scot/Topics/Statistics/Browse/Health/Data/HomeCare#top Comments: This survey collects information on everyone who receives a direct payment to purchase services and respite care services. The findings from this survey are published in November of each year.	

Local	The sources for this type of data will vary across each local authority and/or health board area. It may include: • Local authority data. • Information from commissioning and monitoring reports. • Experiential data collected from service users, such as user feedback.	Each service and organisation will have its own approach to evaluating its service. Nonetheless, there is likely to be a need to centralise some of this information, particularly for projects supported through the Integrated Care Fund. This will enable some consistency across the projects, services and sectors.	**Care Commission**
Individual	This data can be collected in a range of ways including personal outcome-tracking methods such as outcomes stars.	**Individual feedback** from evaluation surveys, etc.	**Care Commission**

5. Health Inequalities and Prevention

This section focuses on health inequalities and how TSIs and the wider third sector can support, implement and measure preventative approaches to health and social care. It includes: contextual information; links to relevant external resources; and an overview of different approaches to evaluating preventative interventions.

5.1 Introduction

Integration is about improving health and wellbeing in a broader sense than just through clinical services. As a result, each of the Integration Authorities, alongside the community planning partnerships, is expected to look beyond only supporting those with long-term conditions and instead to focus on preventative care and early intervention. This is one of the aims of the Integrated Care Fund.

This section of the handbook provides some background information and resources on health inequalities and taking a preventative approach. In particular it will highlight some of the main challenges in implementing and evidencing preventative approaches and offers some tools which may be of use.

5.2 Health Inequalities

Health inequalities are now a major focus of work for both the Integration Authorities and the Community Planning Partnerships. Achieving them will be a long and complex task.

5.2.1 Understanding Health Inequalities

Health inequalities are defined by the World Health Organisation as "*avoidable inequalities in health between groups of people within, and between, countries*."[11] These arise from inequalities within society and are the result of social, economic and political conditions. Health inequalities not only impact on people's risk of illness but may also affect the actions taken to prevent them becoming ill or to treat illness when it occurs.

The infographic overleaf (Figure 5) has been created by NHS Health Scotland to highlight the extent to which health inequalities between two areas in Edinburgh affect the life expectancy of individuals.

[11] World Health Organisation: http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/

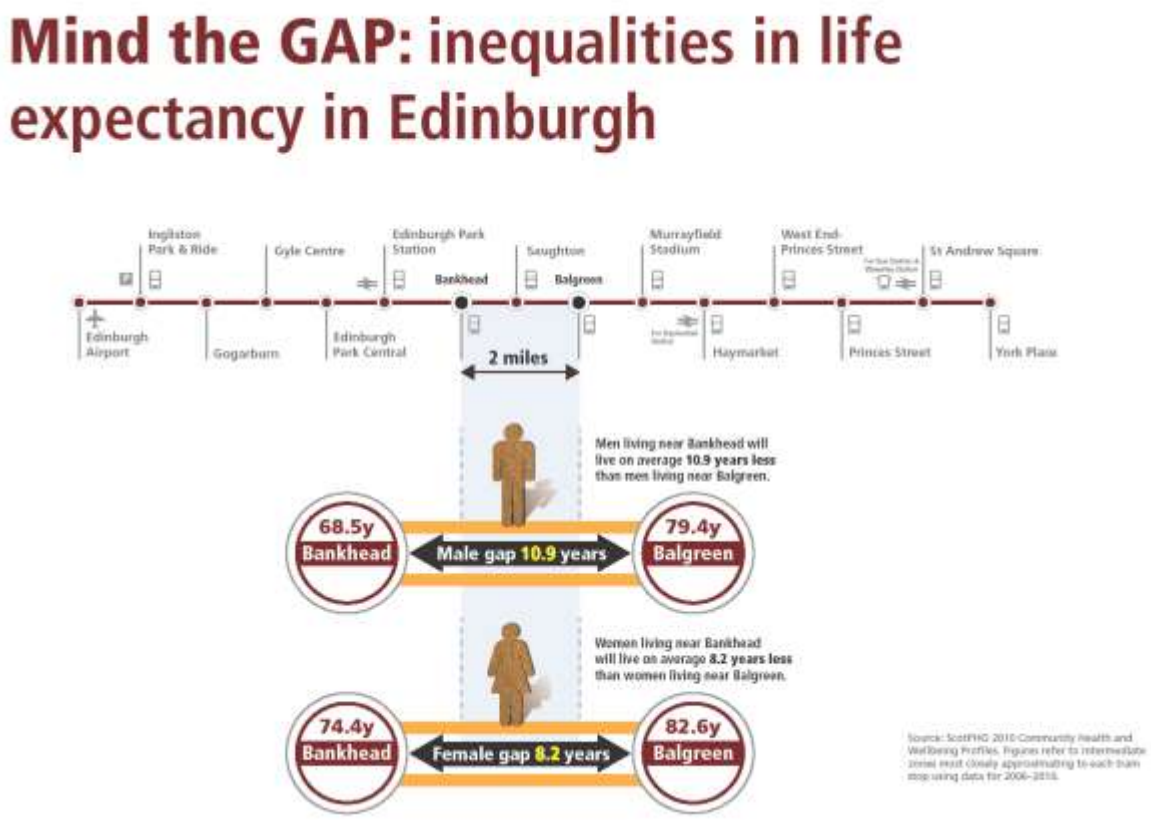


Figure 5 – Health Inequalities Infographic, NHS Health Scotland (26 March 2015)

The fundamental causes of health inequalities are outside the control of Integrated Authorities. However, the wider environmental influences such as housing, welfare, community links, education and food can be influenced or changed by Integrated Authorities, their community planning colleagues and partners across the third sector. The complexity of inequalities means that it is not, and cannot, be the responsibility of any single organisation or sector to address them. Nor should it be exclusively the concern of those whose work relates directly to health or social care. Instead it requires a joined-up approach between various agencies to reduce inequalities that impact on people's wellbeing and life chances.

This is one of the main opportunities of integration: it is hoped that, by employing a more co-ordinated approach to health and wellbeing across services, organisations and sectors, better outcomes will be delivered for individuals and communities living in Scotland.

5.2.2 Addressing Health Inequalities

Health inequalities are diverse and complex, and it is unlikely that any intervention will be successful on its own. Instead, a range of interventions working in collaboration is more likely to achieve the long-term impact required to reduce health inequalities. This is highlighted in a 2007 report to the ministerial task force on health inequalities, in which Professor Sally Macintyre asserts that we need a mixture of 'upstream' (strategic and

legislative-level) and 'downstream' (individual and community-level) interventions to reduce health inequalities.

As well as employing different levels of interventions, a report by Audit Scotland also reinforces the importance of collaboration in this area:

> *"Reducing health inequalities is challenging and requires effective partnership working across a range of organisations. CPPs need to clarify the roles and responsibilities of local organisations in tackling health inequalities, and ensure that they take sufficient ownership of initiatives."*
>
> Audit Scotland, 'Health Inequalities in Scotland' (Edinburgh, December 2012), p.28

The third sector has a key role to play in reducing health inequalities, and it is hoped that, through joint working, the Integration Authorities will recognise and utilise the existing skills, experience and resources of each of the partners.

Within this, the TSIs will undertake a range of activities including:

- mapping current third sector activity to identify potential duplication or gaps in services;
- increasing the capacity of local third sector organisations that can contribute to reducing health inequalities;
- sharing relevant information from the Integrated Joint Board to relevant third sector organisations and vice versa;
- connecting appropriate organisations to share learning;
- brokering cross-sector partnerships.

Further Information

Audit Scotland report, 'Health Inequalities in Scotland' (Edinburgh, December 2012): http://www.audit-scotland.gov.uk/media/article.php?id=221

NHS Health Scotland report, 'Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities' (NHS Scotland: Edinburgh, June 2013): http://www.healthscotland.com/uploads/documents/23047-1.%20HealthInequalitiesPolicyReview.pdf

Various, 'Equally Well: Report of the Ministerial Task Force for Health Inequalities' Vol. 2 (The Scottish Government: Edinburgh, June 2008): http://www.gov.scot/Publications/2008/06/09160103/0

5.3 Prevention

The 32 Community Planning Partnerships will already have some strategies in place to help reduce health inequalities in their area. Nonetheless, the Integration Authorities also have a vital role to play, particularly with regard to prevention and early intervention.

In response to the 2011 Christie Commission, the Scottish Government has placed a huge emphasis on prevention as one of the four core pillars of its public service reform. The aim behind this is twofold:

- to improve health and wellbeing outcomes for people living in Scotland; and
- to reduce some of the pressure on public services.

With increasing demand for services coupled with a contraction in public funding, the latter is becoming increasingly important.

Note: The four core pillars of public service reform are:

- Prevention – reducing future demand by preventing problems arising or dealing with them early on.
- Performance – applying reliable improvement methods to ensure services are consistently well designed, based on best evidence and delivered by the right people to the right people at the right time.
- People – creating ways for people and communities to co-produce services and ensuring that the full creativity and potential of people, communities and organisations is unlocked.
- Partnership – enabling local partnership and collaboration between the public, third and private sector, together with communities.

More information on public service reform can be found on the Scottish Government's website here:
http://www.gov.scot/Topics/Government/PublicServiceReform

5.3.1 Preventative Spending

Preventative spending is an area of concern for both the Scottish Government and the Integration Authorities. Essentially it refers to spending that addresses issues at an early stage, before they become too severe. On a local level it is hoped that the Integrated Care Fund will provide organisations with resources to adopt a more preventative approach rather than one of crisis intervention.

Nonetheless there are a number of challenges surrounding preventative spending which must be tackled by each of the Integration Authorities:

- By prioritising preventative spending, some **resources which are currently dedicated to crisis intervention must be redirected**. While this may prove more effective in

terms of service delivery in the long term, it may prove to be unpopular with individuals and communities who currently use the crisis intervention services. *As a result it is important for individuals, communities and cross-sector organisations to be actively involved in the decision-making process from the start. This will help to empower people to inform decisions which affect them, either directly or indirectly.*

- Shifting the focus to prevention may require **shifting the current balance of power** and this could create tensions within some of the local partnerships involved in health and social care. For example, it may require challenging existing and long-established services, and it may involve the delegation of certain responsibilities and powers.
  In order to address this, there needs to be clear and honest communication between the partners as well as clearly defined priorities and outcomes. This will enable each of the partners to understand, and feel a part of, the bigger picture.

- There is an **element of risk-taking** involved in adopting a preventative approach. This is primarily due to a lack of existing evidence in this area. In addition to this, most preventative interventions require a long-term commitment, but the majority of funding in question is short-term.
  The Integrated Joint Board needs to have a clear and consistent understanding of what the priorities are for its area and what short-, medium- and long-term outcomes it hopes to achieve. An accessible and robust process for monitoring and evaluation should then be put in place across all of the projects/services being supported through integration, to develop a better sense of what is working and what is not.

It should also be noted that preventative spending does not necessarily mean that there will be less expenditure of public money in the short term. While this may be an anticipated aim in the long term, the savings are not going to be appear quickly and may not be seen for many years to come. This does not mean that they are not succeeding in improving the quality of life for individuals – a key consideration when developing a preventative agenda.

The main theme that underpins the challenges listed above is the need for evidence that evaluates the impact of different interventions. In particular, with regard to monitoring preventative spending, there is a need to evidence the impact of investment by calculating the cost–benefit ratio.

The following sections explore some of the challenges to and ways of evidencing the impact of, preventative approaches, and provide links to relevant sources.

5.3.2 Approaching Prevention

There are a number of considerations the Integration Authorities need to consider if a shift towards prevention is going to be successful. These are outlined below.

Step 1 – Defining Prevention

The key questions each Integrated Joint Board needs to ask itself are:

1. What do we mean by prevention?
2. What is it that we're trying to prevent?
3. Why are we trying to prevent this?

On the surface each of these questions may appear to be quite obvious, but it is important to ensure that there is consistency in the answers across all of the partners or it could create tension further down the line.

Question 1: What do we mean by prevention?

The term 'prevention' is a surprisingly vague term that encompasses a number of aims and definitions depending on who is using it.

It is generally accepted that there are three levels of prevention. Despite this, different terms are assigned to each level, and there are nuances in how each one is understood. The three main levels are:

- **Primary/upstream/prevention**. Essentially this is focused on whole populations and systems and aims to prevent harm before it occurs.
- **Secondary/midstream/mitigation**. Essentially this focuses on 'at risk' groups and aims to mitigate the effects of harm or the potential future impact.
- **Tertiary/downstream/coping**. Essentially this is coping with the consequences of harm and trying to stop things from getting worse.

Early intervention is equally problematic as a term: in some instances it is used interchangeably with the term 'prevention' but in others it relates to early-years services, for young people aged 0–5.

Anticipatory care usually refers to a process designed to support patients living with a chronic long-term condition which helps to plan for (an) expected change(s) in the future. As a result, some of the partners may have different views about where on the prevention scale this sits.

While 'prevention' was previously defined in terms of what was missing, there are various organisations now who prefer to describe it in more positive terms, by focusing on characteristics such as resilience or sustainability. For example, rather than defining an outcome as 'fewer young people are involved in the criminal justice system', it could be 'more young people are able to make better life choices' and 'more young people reach positive destinations'.

Note: Developing a shared definition from the start will allow the Integration Authorities to communicate more effectively as a partnership. It will also be important for the partners to clarify how they are using the terminology to their wider stakeholders. This will promote consistency in understanding across the local authority area.

The TSI will have a key role to play in this as a conduit between the Integration Authority and the wider third sector. It will enable:

- evidence and views from the wider third sector to be heard by the Integrated Joint Board.
- The dissemination of definitions and understandings of prevention to the wider third sector.

Question 2: What is it that we're trying to prevent?

Being clear about this from the outset will not only help to ensure that resources are targeted in line with a specific aim, but will also help to promote a coherent message to the main stakeholders in the integration process. This includes relevant organisations within the wider third sector and their beneficiaries.

The Scottish Government has published a number of national outcomes and indicators upon which it expects each Integrated Joint Board to report annually. The way in which these are achieved will vary across each area, and the activities and interventions will respond to identified needs and priorities in the area.

There are different sources of information which will help the Integration Authority to identify its own priorities. These include:

- *Gathering and listening to local views*: One of the central roles of the TSI in integration is to act as a conduit between its wider third sector and the Integration Authority. As a result it will have a key role to play in helping to determine the priorities for the area. It will be up to each TSI to determine the best way to achieve that, for example through a survey, forum, one-to-one conversations, social media, or a combination of methods. It will then be up to the Integration Authorities, including a representative from the third sector, to collate the responses and to consider them alongside the Strategic Plans for integration locally.
- *Using existing data*: The statutory partners will have access to existing data, which will also help to identify priorities for prevention. Where relevant, this should be shared and communicated with wider health and social care partners so that everyone has consistent information.

Other useful sources of online data are included in the box below.

Tools

The Scottish Public Health Observatory (ScotPHO) has produced a publically available 'Online Profiles Tool' which will enable partnerships to explore how health in their local authority compares to others. By providing a broad picture of health in Scotland it aims to enable resources to be appropriately targeted to reduce inequalities. The profiles and overview reports can be accessed here: http://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool

'Understanding Scottish Places' (USP) brings together data about places and people in Scotland into one visual and searchable database. As well as providing information about towns with a population of over 1,000 people, it also offers potential comparators by highlighting areas which have similar data. This will allow the Integration Authorities to develop a greater understanding of their own area(s) but to also potentially learn lessons from other areas. The website can be accessed here: http://www.usp.scot

Question 3: Why are we trying to prevent this?

Again, this may appear to be a simple question, but each of the partners and stakeholders may have a slightly different motivation for an agenda on prevention. For example, the key driver for one partner may be to improve health and wellbeing outcomes for individuals, for another it may be to reduce public spending in certain areas; it may be to reduce growing pressure on public services, or it may be a combination of reasons.

Note: It is important for each of the partners to have an honest conversation about their own motivations. This will not only create a better understanding of each other's position within the partnership, but will also be essential when developing a monitoring and evaluation framework for projects and services funded through the Integrated Care Fund.

The TSI will also need to gather relevant views from the wider third sector on this area, to ensure that a diversity of voices is heard.

Step 2 – Monitoring and Evaluating Preventative Interventions

Identifying how to measure the impact of preventative interventions is one of the biggest challenges in this area and one to which there is no clear answer.

In June 2015, VAS facilitated a TSI practice forum which explored some of the challenges around understanding and evidencing prevention. Some of the main issues discussed on the day included:

- Short-term funding versus long-term aims and outcomes.
- Finding the resources necessary to complete an evaluation which can often be complex and lengthy.
- Identifying what changes were caused by the TSI's intervention as opposed to other factors (contribution versus attribution).
- Generating solid evidence – how do you predict something that hasn't happened?

A report by Audit Scotland into health inequalities in Scotland also recognised some of these challenges. It highlighted the need for a systematic approach to monitoring these types of interventions, particularly with regard to evaluating the cost-effectiveness of different interventions.

"The Scottish Government and Community Planning Partnerships need a more systematic approach to assessing the cost-effectiveness of actions to reduce health inequalities. Changes may not take effect for a generation or more, making the measurement of success in the short term difficult. However, many initiatives lack a clear focus from the outset on cost-effectiveness and outcome measures. This means that assessing value for money is difficult."

Audit Scotland, '*Health Inequalities in Scotland*' (Edinburgh, December 2012), p.28

A few potential methodologies for monitoring projects aimed at prevention and early intervention are listed below, and there are additional resources at the end of this section.

Note: Prevention in its purest sense is also about building capacity and resilience so that risk factors are diminished. It is therefore recommended that evaluations of prevention look at what has been created as well as what has been taken away, i.e. promoting resilience rather than just reducing harm.

Logic models

A logic model (also known as a theory of change or logical framework) is a useful tool for evaluating the effectiveness of a programme/intervention. It helps organisations to think

about the aims, activities and outcomes of their projects or services. In particular it is useful for highlighting the causal connection between the identified need, the outputs of a project and the intended outcomes. From here it is easier to identify appropriate evaluation tools to see if they have been achieved and, moreover to highlight any unexpected outcomes of the project/service.

As well as potentially supporting the creation of logic models for the Integration Authority's overall Strategic Plan, it is also anticipated that the TSI may have a role to play in supporting wider third sector organisations to use tools such as these to identify the outcomes their individual interventions are likely to achieve.

Further Information

Evaluation Support Scotland has published a number of useful documents on logic models including a guide to developing a personal one: http://www.evaluationsupportscotland.org.uk/media/uploads/resources/supportguide1.2logicmodelsjul09.pdf

It also led a programme called 'A Stitch in Time,' in collaboration with the Joint Improvement Team and the Scottish Government. This aimed to show the role played by the third sector in Reshaping Care for Older People (RCOP). This used a number of logic models to make reasoned assessments about how the third sector supports and complements the work of other sectors. Publications relating to the findings and the processes can be accessed through the Evaluation Support Scotland website, here: http://www.evaluationsupportscotland.org.uk/stitch-time-lothian/

There will also be a follow-up programme called 'Threading the Needle'. This will work with four areas to use third sector evidence to commission outcomes for health and social care. At the time of publication for this handbook expressions of interest for the programme were being submitted. It is anticipated that there will be a number of related documents disseminated throughout the process which may be of use to areas which are not directly participating in it.

Examples of using Logic Models for planning are included in a separate document.

Measuring 'soft outcomes'

So called 'soft outcomes' are essential to evidencing the impact on individuals using a service or specific type of approach. There is a range of different approaches that can be employed, e.g. storytelling, questionnaires, focus groups, interviews, outcome stars, etc. It is likely that a range of approaches will be utilised, but it is recommended that there is some consistency in how these are used across each area.

Note: If there is no consistency, it will be difficult to compare the evidence and to create an overview of the collective impact of the interventions.

This handbook does not include an exhaustive list of potential methodologies but instead offers links to some external resources which may be useful to create a harmonised reporting system.

Tools

The Early Intervention Foundation has published 'A Guide to Tools and Resources.' This contains a number of links to help you through the process of identifying where you are, what works, and measuring the success of your own interventions. Although many of these links are for projects based in England, there is still a lot of learning which will be of relevance in a Scottish context: http://www.eif.org.uk/wp-content/uploads/2014/03/Tools-and-Resources.pdf

The Big Lottery Fund has developed a guide for evaluating wellbeing which it used on its own Wellbeing Programme: https://www.biglotteryfund.org.uk/research/making-the-most-of-funding/impact-and-outcomes/evaluation-methodology

The Campaign to End Loneliness has developed a tool for measuring the impact on loneliness in later life http://www.campaigntoendloneliness.org/wp-content/uploads/Loneliness-Measurement-Guidance1.pdf

Its website also includes a number of existing evidence bases which may also be useful for underpinning the monitoring for various third sector interventions.

Evaluation Support Scotland has a number of resources designed to help third sector organisations monitor and evaluate their own projects: http://www.evaluationsupportscotland.org.uk/resources/tools/

Cost–benefit analysis

A logic model is useful for helping us to see what outcomes are likely to be met through a project or intervention. This is important when evaluating different interventions, particularly if the key driver is to improve health and wellbeing outcomes for individuals. Nonetheless, one of the motivations for integration is to provide more effective use of public money. As a result, cost-benefit analysis is useful tool for identifying the potential savings that be made through a particular intervention.

It is important to note, however, that short-term monitoring will only ever be able to show **potential** savings to the public purse. This is because, even if an intervention reduces the number of GP consultations, the GP will still be employed and their costs will still need to be met. Therefore the savings are often savings of time that is freed up to do something else, rather than actual financial savings.

This handbook will not provide a step-by-step guide to conducting a cost-benefit analysis but some useful links to support you with this type of analysis have been included below. These relate to how you might approach a cost-benefit analysis as well as existing data on various unit costs.

Tools – Approaches

The Big Lottery Fund published guidance for its grant-holders and other third sector organisations to help them undertake a cost-benefit analysis: https://www.biglotteryfund.org.uk/research/making-the-most-of-funding/impact-and-outcomes/monitoring-and-evaluation

The Early Intervention Foundation has developed a checklist with criteria and guidance to help commissioners assess and improve the cost-benefit analysis of their business case: http://www.eif.org.uk/publications/making-an-early-intervention-business-case-checklist-and-recommendations-for-cost-benefit-analysis/

It has also produced a guide to help develop organisations to develop a business case based on cost-benefit analysis: http://www.eif.org.uk/publications/making-an-early-intervention-business-case-what-should-it-look-like – this is likely to be of use to both the TSIs and the wider third sector, and more information can be found in Section 6 of this handbook.

Tools – Existing Data

The Personal Social Services Research Unit has compiled an online document which outlines unit costs for a range of activities, e.g. cost per GP consultation, cost per community nurse visit. So, if you can evidence that a successful preventative project has led to fewer GP consultations, this may help you to calculate potential savings to the public purse.
http://www.pssru.ac.uk/project-pages/unit-costs/2014/

Safer Communities Scotland has published a number of documents relating to preventative spend and costings. Some of these are a few years old but it provides an idea of some of the costs involved in different interventions. More detailed and up-to-date information can also be requested from the relevant statutory partners on the Integration Authority. http://www.safercommunitiesscotland.org/search-results.html?search=preventative+spend&id=287

Using existing evidence

In most instances the monitoring and evaluation requirements will be short-term while the anticipated changes will be long-term. Indeed, the impact of some preventative interventions will not be seen for a generation or more. This creates a challenge for monitoring such interventions and is why external studies and evidence can be particularly useful: although you might not yet be able to prove the long-term impacts of your own intervention, you can link your own evaluation to existing evidence and form reasonable conclusions about your own preventative impact.

For example, there is a range of evidence showing that loneliness and social isolation impacts negatively on a person's mental and physical health.[12] Suppose that a recent evaluation of your befriending project showed that it reduced instances of social isolation for the majority of beneficiaries. From here you can make a reasoned assumption that your project will improve people's mental and physical health. This may mean that they require fewer GP appointments, fewer hospital admissions or less intensive social care; but this would need to be clearly evidenced through your own or other people's evidence.

Note: You need to be able to draw a clear line between your own activities and the external evidence. Make sure all sources are clearly cited and that anyone else can follow the thought process from A (current outcomes) to B (longer-term outcomes and evidence of something being prevented). If people think that you're being too ambitious in your claims they may be wary about other evidence that you present.

Step 3 – Using the Data

It is likely that the data collected on preventative interventions will be used for a variety of purposes within the Integration Authority. These include:

- Reporting to the Scottish Government on annual progress;
- Internally monitoring the progress of integration locally and adapting interventions or approaches where necessary;
- Monitoring the impact of Integrated Care Fund monies and developing future allocations accordingly.

Because of these different uses, the Integration Authority will need to ensure that all data is gathered in as consistent and robust a way as possible. Data will also need to be reviewed regularly (perhaps at six-monthly intervals) so that any gaps in the information or issues with projects can be swiftly identified and remedied. There is more information on how the data can be used effectively by the partners in **Section 4** of this handbook.

[12] For example, Sylvia Bernard, *Loneliness and Social Isolation among Older People in North Yorkshire*, Working Paper No.WP 2565 (April 2013), pp.9–10, available online: http://www.york.ac.uk/inst/spru/research/pdf/lonely.pdf (last accessed 01/09/15)

5.4 The Role of the TSI and the Wider Third Sector

For a preventative approach to be effective, it needs to be a collaboration between various sectors, agencies and organisations. This is because no issue exists in isolation and so a holistic approach needs to be adopted. This is important to recognise, as it means that each of the partners and stakeholders will have a vital role to play in shifting the focus towards prevention and away from crisis intervention.

This section has highlighted that the TSI will have a vital role to play in:

- gathering and disseminating relevant information between the Integration Authority and the wider third sector;
- building the capacity of organisations that may be able to contribute to a preventative agenda in the area;
- ensuring the voices of the wider third sector are considered when adopting a more preventative approach;
- promoting a shared understanding of the priorities for prevention in the area and why this is the case;
- supporting wider third sector organisations to monitor and evidence the impact of their own interventions; and
- using the growing evidence base to reinforce the central role that the wider third sector has to play within this agenda.

6. Resourcing a Local Case

This section brings together the key points from the preceding chapters into one easy-to-use checklist. Working through this will help the TSI to understand what still needs to be done in order to effectively engage its wider third sector in health and social care integration.

By using the tools in this handbook, alongside existing knowledge, partnerships and local structures, TSIs should be able to build a local case to support third sector engagement in integration more effectively.

Using the checklist below should help with the consideration of what is needed for the creation of any logic model or for building business cases for new projects. This will facilitate the sector's contribution to integration.

Understanding Integration	**Comments**
Does the third sector understand the background to integration – why it's happening and what it's intended to achieve?	
Does the third sector understand the principles of integration?	
Does the third sector know what is – and is not – being integrated?	
Has the third sector locally considered the implications for the sector?	
Has the sector considered what changes are required in the mid to long term and prepared a plan to achieve this?	
Shaping the Role of the TSI and Third Sector	**Comments**
Has the TSI undertaken a process of shaping and framing its role in integration in the short, medium and longer term?	
What resources are required to enable that to happen?	
Has the TSI defined what it will – and will not – be able to do as a partnership broker?	
Have existing partnerships and relationships been scoped?	
Has the sector considered how partnerships and relationships need to change?	

Is the local third sector ready for the changes being brought about by integration?	
What resources are required to improve that readiness?	
Joint Strategic Commissioning	**Comments**
Is the third sector aware of the Strategic Commissioning Plan?	
Has the third sector contributed to the development of the Strategic Commissioning Plan?	
Is the third sector ready for this plan to be implemented?	
What needs to be in place to improve this readiness?	
Has the third sector considered its contribution to overcoming any barriers to improving commissioning?	
Has the third sector prepared a case for investing in partnerships?	
Gathering and Using Data	**Comments**
Does the third sector understand the role of data in planning and commissioning?	
Does the third sector understand how its range and types of data can contribute to improving commissioning?	
Does the third sector have the knowledge, skills and infrastructure needed to enable this contribution?	
What capacity building is required to ensure the third sector contribution can be maximised?	
Health Inequalities and Prevention	**Comments**
Does the third sector understand health inequalities and its place in integration?	
Does the third sector understand its range of contributions to reducing health inequalities?	
Does the third sector understand the approaches to prevention that it is able to contribute to?	
Does the third sector understand how the shift to prevention will happen locally?	

What resources are required to ensure that the third sector's contribution to reducing health inequalities and prevention is enabled?	
What Needs to Happen	**Comments**
Is the third sector aware of what is already being done?	
Is the third sector aware of what needs to be done?	
What does the third sector believe it can contribute?	
What value can the third sector bring to integration?	
What is required to achieve this contribution and value?	

Glossary

There is a Glossary included in the Communications Handbook from Scottish Government. It is reproduced here to provide you with an understanding of what Scottish Government means by these terms.

It should be noted that others, particularly some national health and social care third sector organisations, disagree with some of the definitions here and in some cases with the philosophy underpinning the definition – this 'dual meaning' of some words may well cause lack of coherence and understanding in some discussions about integration that occur locally.

2020 Vision: The 2020 Vision provides the strategic narrative and context for taking forward the implementation of the Quality Strategy, and the required actions to improve efficiency and achieve financial sustainability.

Anticipatory Care: Anticipatory care can take many forms; however, it is expected to help reduce avoidable and unscheduled acute admissions for people with pre-existing conditions. The purpose of advanced/anticipatory care planning is to support the individual to have greater choice, and control of care preferences, through communication across the support team, across agencies and across care settings.

Body Corporate Model: The Body Corporate model is a model of integration where a Health Board and local authority both delegate the responsibility for planning and resourcing service provision for health and social care services to an Integrated Joint Board, established as a separate entity.

Chief Officer: Where the Body Corporate model is adopted, a chief officer of the Integrated Joint Board will be appointed to provide a single point of management for the integrated budget and integrated service delivery. He or she is accountable to the Integrated Joint Board and to the Chief Executives of the Health Board and local authority for the delivery of integrated services.

Choice and control: Choice and control is about shaping services to meet people's needs, rather than allocating people to fit around services.

Co-production: Co-production is about combining our mutual strengths and capacities so that we can work with one another on an equal basis to achieve positive change.

Delayed Discharges: Delayed discharges occur when a patient ready for discharge cannot leave hospital because the necessary care, support or accommodation is not available.

Delegation: Delegation is the process used to integrate functions, by giving responsibility for health and social care functions to a single body.

Aids and Adaptations: Aids and adaptations can help older and disabled people to live independently in their own homes. They can reduce the risk of falls and other accidents in

the home and can also reduce the need for home care or long-term admission to a care home.

A wide variety of aids and equipment is available to help with daily living tasks, ranging from simple adapted cutlery, to tele-care alarms, specialist seating and beds. Common examples of adaptations include replacing a bath with a level-access shower, or making it easier to get in and out of the home by widening doors or constructing a ramp.

Health Inequalities: 'Health inequalities' is the term for the gap that exists between the health of different population groups such as the affluent compared to poorer communities or people with different ethnic backgrounds.

HEAT Targets: The HEAT performance management system sets out the targets and measures against which Health Boards are publicly monitored and evaluated. HEAT is an acronym for Health Improvement, Efficiency and Governance, Access and Treatment. These are the four areas being targeted.

Independent Living: Independent living means having the same freedom, choice, dignity and control as other citizens at home, at work and in the community. It does not necessarily mean living by yourself or fending for yourself. It means rights to practical assistance and support to participate in society and live an ordinary life.

Independent Sector: The independent sector encompasses individuals, employers and organisations who contribute to needs-assessment, design, planning, commissioning and delivery of a broad spectrum of social care services, which are wholly or partially independent of the public sector.

The independent social care sector in Scotland includes care homes, care at home, and housing support and day care services. The sector encompasses those traditionally referred to as the 'private' sector and the 'voluntary' sectors of care provision. It includes organisations of varying types and sizes, amongst them single providers, small and medium-sized groups, national providers and not-for-profit voluntary organisations, associations and charities.

Integration: Integration is the combination of processes, methods and tools that facilitate integrated care.

Integrated Care: Integrated care focuses on improving services in relation to access, quality, user satisfaction and efficiency. The aim is to enable better-co-ordinated, joined-up and more continuous care, resulting in improved patient experience whilst achieving greater efficiency and value from health and social care delivery systems.

Integrated Resource Framework: The Integrated Resource Framework (IRF) for Health and Social Care is a framework within which Health Boards and local authorities can better understand the patterns of care they provide, particularly to their shared populations of people and service-users.

Integration Authority: An Integration Authority is the body that is responsible for planning integrated care. It will decide which integrated services will be provided, how they will be funded and what they should look like. It can (and in many cases must) direct the Health Board and local authority to deliver those services. The body that acts as the Integration

Authority for a particular area will be determined by reference to the model of integration used in that area.

Integration Functions: The services that Integration Authorities will be responsible for planning are described in the Act as integration functions. The legislation sets out which NHS and social care services must, may and cannot be delegated as part of the integration arrangements.

Integration Joint Board: Where the Body Corporate model is adopted, the NHS Board and local authority will create an Integrated Joint Board made up of representatives from the Health Board, the Local Authority, the third and independent sectors and those who use health and social care services. The Integrated Joint Board, through its chief officer, will have the responsibility for the planning, resourcing and operational oversight of integrated services within the Strategic Plan.

Integration Scheme: An integration scheme is the agreement made between the Health Board and the local authority. It sets out the make-up of the Integration Authority and how it will work. The Health Board and the local authority were obliged to submit their draft Integration Scheme to Scottish Ministers for approval by 1 April 2015. Integration schemes must be reviewed by the Health Board and local authority at least every five years.

Intermediate Care: Intermediate care services support people to improve their independence and aim to provide a range of enabling, rehabilitative and treatment services in community and residential settings. The term has been defined as a "range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living". (NSF for Older People, DOH, June 2002).

Lead Agency Model: The Lead Agency model is a model of integration where the Health Board or the local authority takes the lead responsibility for planning, resourcing and delivering integrated adult health and social care services.

Locality Planning: Locality planning is intended to keep the focus of integration on improving care in local communities. It will draw on the knowledge and experience of users of services, carers, staff and the third and independent sectors and provide the route for leadership by local clinicians and professionals from across health and social care – and, particularly, GPs – in planning service provision. Every local authority must define at least two localities within its boundaries for the purpose of locality planning.

Long-term Conditions: Long-term conditions are conditions that last a year or longer, impact on many aspects of a person's life, and may require ongoing care and support. The definition does not relate to any one condition, care group or age category, so it covers adults and older people as well as children and those with physical and mental health issues.

Common long-term conditions include epilepsy, diabetes, some mental health problems, heart disease, chronic pain, arthritis, inflammatory bowel disease, asthma and chronic obstructive pulmonary disease (COPD).

Market Facilitation: Market facilitation is a key aspect of the strategic commissioning cycle. Authorities will undertake a range of activities to promote the successful development of services to meet the needs of the local population effectively. These activities should

include the development of an accurate picture of local need and markets, published as a Market Facilitation Plan.

National Care Standards: The National Care Standards have been published by Scottish ministers to help people understand what to expect from a wide range of care services. They are in place to ensure that people get the right quality of care when they need it most.

National Health and Wellbeing Outcomes: The nine National Health and Wellbeing Outcomes provide a national framework for measuring the effect of integrated health and social care services on the health and wellbeing of individuals.

Personalisation: Personalisation means starting with the individual as a person with strengths and preferences who may have a network of support and resources, which may include family and friends. Personalisation reinforces the idea that the individual is best placed to know what they need and how those needs can be best met. It means that people can be responsible for themselves and can make their own decisions about what they require, but that they should also have information and support to enable them to do so.

Person-centred: A person-centred approach is an approach to working with people which respects and values the uniqueness of the individual and puts the individual's needs and aspirations firmly at the centre of the process.

Planning and Delivery Principles: The principles that underpin the making of arrangements for integration, and the strategic planning of integrated services, will inform how services are planned and delivered. They explain what people using services and their carers can expect from integrated services and the behaviours and priorities expected of organisations and people planning and delivering care and support.

Quality Ambitions: The three Quality Ambitions of *person-centred*, *safe* and *effective* provide the focus for all our activity to support our aim of delivering the best-quality healthcare to the people of Scotland and, through this, making NHS Scotland a world leader in healthcare quality. They explicitly reflect the things people have told us they want and need.

Quality Strategy: The Healthcare Quality Strategy for Scotland is the approach and shared focus for all work to realise the 2020 Vision. It aims to deliver the highest-quality healthcare to the people of Scotland to ensure that the NHS, Local Authorities and the third sector work together, and with patients, carers and the public, towards a shared goal of world leading healthcare.

Reablement: Reablement is about giving people the opportunity and the confidence to relearn/regain some of the skills they may have lost as a result of poor health, disability/impairment or entry into hospital or residential care. As well as regaining skill, reablement supports service-users to gain new skills to help them maintain their independence.

Self-Directed Support: Self-Directed Support (SDS) is the new form of social care where the service-user can arrange some or all of their own support. This is instead of receiving services directly from local authority social work or equivalent. SDS allows people more flexibility, choice and control over their own care, so that they can live more independent lives with the right support.

Self-management: Self-management encourages people with health and social care needs to stay well, learn about their condition and their care and support needs, and remain in control of their own health.

Shadow Integration Board: Interim local Shadow Integration Boards have been set up to manage transitional integration arrangements until integration goes live from April 2015.

Staff Governance (NHS Scotland): Staff governance is an NHS Scotland system of corporate accountability for the fair and effective management of staff. It requires that staff are: well informed; appropriately trained; involved in decisions; treated fairly and consistently; and provided with a continually improving and safe working environment.

Staff Partnership: Staff partnership describes the process of engaging staff and their representatives at all levels in the early stages of the decision-making process. This enables improved and informed decision-making, through achieving and maintaining a positive and stable employee relations culture, and gaining commitment, ownership and consensus to decisions through joint problem-solving. The emphasis is therefore placed on working collaboratively at all levels and becoming an exemplary employer, both to the benefit of staff but also to the benefit of patient care.

Strategic Commissioning: Strategic commissioning is a way to describe all the activities involved in:

- assessing and forecasting needs;
- linking investment to agreed desired outcomes;
- planning the nature, range and quality of future services; and
- working in partnership to put these in place.

This is the process that informs the Integration Authority's Strategic Plan.

Strategic Needs Assessment: Strategic Needs Assessments (SNAs) analyse the health and care needs of populations to inform and guide commissioning of health, wellbeing and social care services within local authority areas. The main goal of an SNA is to accurately assess the health and care needs of a local population in order to improve the physical and mental health and wellbeing of individuals and communities. The SNA will underpin Strategic Plans.

Strategic Plan: The Strategic Plan is at the heart of integration and is intended to be the means by which services are redesigned in an integrated way to improve the quality and coherence of care for people using them. Each Integration Authority must put in place a Strategic Plan (Strategic Commissioning Plan) for functions and budgets under its control. These will be co-produced via a Strategic Planning Group, whose members will include representatives of non-statutory partners, service-users and service-user representatives.

Supported Living: Supported living is an alternative to residential care or living with family members that enables adults with disabilities to live in their own home, with the help they need to be independent. It allows people to choose where they want to live, who they want to live with and how they want to be supported.

Third Sector: 'Third sector organisations' is a term used to describe the range of organisations that are neither public sector nor private sector. It includes voluntary and community organisations (both registered charities and other organisations such as

associations, self-help groups and community groups), social enterprises, mutuals and co-operatives. It also includes local intermediary organisations (Third Sector Interfaces), and third sector strategic intermediaries, for example Voluntary Action Scotland (who represent Scotland's 32 Third Sector Interfaces) and the Health and Social Care Alliance Scotland.

Transformational Leadership: As opposed to the management of the delivery of services, transformational leadership relates to the ability to inspire, motivate and engage. These qualities are seen as being particularly important for times when organisations are being challenged by significant external changes.

Appendix A – Background to Integration

This section provides an overview to health and social care integration, including a summary of the legislation, what it means for the TSIs and their wider third sector, and what additional guidance and advice is available.

Overview of Health and Social Care Integration

Health and Social Care Integration is the Scottish Government's ambitious programme of reform to improve care and support for those who use health and social care services in Scotland.

The Vision for Health and Social Care Integration

*Ensuring **better care and support** for people where users of health and social care services can expect to be **listened** to, to be **involved** in deciding upon the care they receive and to be an **active participant** in how it is delivered. This will result in **better outcomes** for people, enabling them to enjoy better health and wellbeing in their homes and communities.*

The Scottish Government recognises that the nature and form of our public services needs to change if they are going to effectively respond to changes in society. With a contraction in public funding, coupled with an ageing population, public services are already struggling to meet demand. This is only likely to increase.

Indeed, in the next 10 years the number of people in Scotland aged over 75 is likely to increase by 75%. It is also estimated that in the same period nearly two-thirds of people will have developed a long-term condition by the age of 65.[13]

The Christie Commission was established to explore how we can reform public service delivery to better meet the needs of individuals and communities, and to address long-standing issues of inequality.

Whilst saving public money was a driver behind the recommendations of the Commission, it should also be noted that it was not the sole reason for the proposed changes: **improved outcomes for individuals and communities** was also seen as essential. Because of this, it also advocated for reforms that empower individuals and communities and which focus on prevention and anticipatory care, thereby reducing the number of negative outcomes that arise.

[13] Scottish Government, *Communications Toolkit: A guide to support the local implementation of health and social care integration* (March 2015), p.7, available online: http://www.gov.scot/Resource/0047/00475356.pdf

Health and Social Care Integration draws on these recommendations for a more co-ordinated and outcomes-focused approach in order to improve the health and wellbeing of individuals and communities in Scotland.

The Legislation

The Public Bodies (Joint Working) (Scotland) Act 2014 provides the legislative framework for the integration of health and social care services in Scotland.

Legislation Overview

Health and Social Care Integration requires the local integration of adult health and social care services, with statutory partners (Health Boards and local authorities) deciding locally whether to include children's health and social care services, criminal justice social work and housing support services in their integrated arrangements.

Key Features of the Act

National outcomes for health and wellbeing will apply equally to Health Boards, local authorities and Integration Authorities. Health Boards and local authorities will be required to establish integrated partnership arrangements. Two models of integration are available for Health Boards and local authorities to choose from:

- delegation of functions and resources between Health Boards and Local Authorities (Lead Agency), and
- delegation of functions and resources by Health Boards and Local Authorities to a Body Corporate (Integrated Joint Board).

An integrated budget will be established in each Integration Authority to support delivery of integrated functions, which will cover at least adult social care, adult community health care, and the aspects of adult hospital care that are most amenable to service redesign in support of prevention and better outcomes.

Each Integration Authority will establish locality planning arrangements at sub-partnership level, which will provide a forum for local professional leadership of service planning.

Each Integration Authority will put in place a Strategic Commissioning Plan for functions and budgets under its control. The joint Strategic Commissioning Plan will be widely consulted upon with non-statutory partners, patient and service-user. Where the Body Corporate model is used, a chief officer must be appointed by the integrated partnership to provide a single point of management for the integrated budget and integrated service delivery. Where the Lead Agency model is adopted, this management role falls to the chief executive of the Lead Agency (i.e. the partner to whom functions and resources are delegated).

The detail of the partnership arrangement will be set out within an Integration Scheme. It will cover matters such as:

- engagement of stakeholders;
- clinical and care governance arrangements;
- workforce and organisational development;

- data sharing;
- financial management;
- dispute resolution;
- local arrangements for the Integrated Joint Board;
- local arrangements for operational delivery;
- liability arrangements; and
- complaints-handling.

The Integration Scheme was required to be submitted to Scottish Ministers for approval by 1 April 2015. Once approved, Scottish Ministers will lay an Order to establish the Integration Joint Board.

Once established, the Integrated Joint Board will:

- appoint a chief officer;
- appoint a finance officer;
- establish a Strategic Planning Group.

Once the Integrated Joint Board and the Strategic Planning Group are satisfied that the Strategic Plan and locality arrangements are fit for purpose, the Integrated Joint Board notifies the Health Board and local authority of the date on which responsibility for integrated services and the budgets should be delegated to the Integrated Joint Board. On that date, integration 'goes live'. All partnerships will go live at some point between 1 April 2015 and 1 April 2016.

The chief officer will have a direct line of accountability to the chief executives of the Health Board and the local authority for the operational delivery of integrated services. The chief officer is responsible for ensuring that service delivery improves the national outcomes, and any locally delegated responsibilities for health and wellbeing. This includes measuring, monitoring and reporting on the underpinning measures and indicators that will demonstrate progress.

Once the resources for the integration functions are delegated to the Integrated Joint Board, it will then make decisions on the use of the integrated finance. The chief officer carries out the decisions of the Integrated Joint Board.

The chief officer and the responsible financial officer of the Integrated Joint Board will work with locality groups to devolve appropriate responsibility and accountability for spending. Integration Authorities will need to ensure that localities are empowered to make decisions that achieve appropriate shifts in outcomes.

Regulations

There are a number of Regulations and Orders which support the Act and provide detail on how different aspects of integrated health and social care should be organised or delivered. These focus on the different ways that structures, processes, cultures and social relationships are required to be integrated by partners.

Scottish Government continues to provide a number of documents to assist with the implementation of integration. They can all be found here:

http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Implementation/Regulations

Of particular note are:

Working in Partnership with Scrutiny Bodies: this note summarises the powers and responsibilities of the scrutiny bodies and sets out the reasoning for how Integration Authorities can work jointly with those bodies.
http://www.gov.scot/Publications/2015/05/6415

The Role of Third Sector Interfaces: sets out the role of TSIs within integration and provides Integration Authorities with guidance on how they can support TSIs to fulfil that role.
http://www.gov.scot/Resource/0047/00475591.pdf

National Health and Wellbeing Outcomes: guidance framework on the national outcomes that apply to integrated health and social care.
https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-ascof-2015-to-2016

Information Framework: a prototype of an information framework for the national outcomes.
http://www.hscic.gov.uk/nhsof

Integration Planning and Delivery Principles: guidance on the planning and delivery principles which describe how integrated care should be planned and delivered and how the principles work in tandem with the national outcomes.
http://www.gov.scot/Resource/0046/00466005.pdf

Strategic Commissioning Plans: guidance for everyone involved in the commissioning of health and social care services.
http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Implementation/ImplementationGuidance/SCPlans

Localities Guidance: sets out what localities are for, the principles upon which they should be established and the ethos under which they should operate.
http://www.gov.scot/Publications/2015/07/5055

National Health and Wellbeing Outcomes

Many of the supporting documents for integration emphasise the change of focus towards outcomes. However, it is important to understand these outcomes and what is being referred to. Some of the documents refer to patient or individual outcomes and others to national health and social care outcomes – often these two terms are being used interchangeably – but this is not the case. Individual outcomes are being measured as a sub-set of the national outcomes.

A list of the nine National Health and Wellbeing Outcomes can be found here: http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes

Each Integration Authority will be required to publish an annual performance report which will set out how they are improving the National Health and Wellbeing Outcomes. These reports must include information about the core suite of indicators which have been developed in consultation with COSLA, NHS Scotland and the third and independent sectors. More information on these is available on the Scottish Government's website: http://www.gov.scot/Resource/0047/00473516.pdf

These indicators will be supported by local measures and contextualising data to provide a broader picture of local performance. Indeed, as has previously been suggested, the national outcomes are required to understand the progress of integration on a national level but these only tell part of the story. Additional local data – both from statutory and non-statutory sources – will help create a more rounded picture of what is happening.

Further Information

Section 2.4 of this handbook provides more information on the role of the TSI in synthesising and communicating information while Section 4 offers more detail on potential data sources.

To achieve success in both quality and outcomes, significant changes are likely to be required.

A deepening of engagement with individuals about both the quality aspects of services, as well as the effectiveness of services, will have to take place.

A willingness to try out ideas generated from within the community is likely to be supported.

An understanding of the contribution of other services (outside of health and social care) to the national health and well-being outcomes and to individual outcomes will have to be evidenced (see **information synthesising**).

Throughout this work it may be useful for TSIs to bring discussions back to people – if local aims are truly to be about improving outcomes that matter to people using services, then Integration Authorities' discussions should be about more than structures and processes. Although it is easy to understand how structures, etc. are likely to be the focus of discussions in the early stages, it will be necessary to move those discussions on to other aspects of change, including vision, leadership, culture, local context and so on, in order to achieve the desired aims.

Human-Rights-Based Approach

The National Health and Wellbeing Outcomes and the integration planning and delivery principles are grounded in a human-rights-based approach – the principle that people should be equal and free to participate as full and active members of society and live with dignity, and participate in our communities equally.

A human-rights-based approach is a way of enabling people to know and claim their rights. It increases the empowerment and accountability of individuals, organisations and the relevant professionals who are responsible for respecting, protecting and fulfilling rights. This means giving people greater opportunities to participate in shaping the decisions that impact on their human rights.

The Scottish National Action Plan (SNAP) on Human Rights recognises that human rights impact on all of us through a basic assumption of humane, dignified, fair and equal treatment in our homes, schools, workplaces and communities. The Scottish Government will design and lead a programme of work to ensure that human rights is placed at the heart of integration of health and social care, including in outcome measures and guidance.

http://www.gov.scot/Publications/2015/02/9966/9