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Children in Scotland

Integrating Health and Social Care in Scotland: The Impact on Children's Services

Part 1: Literature and policy review

CELCIS, Children in Scotland and Care Inspectorate

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Contents

Preface

This Literature and Policy Review is one of two reports exploring the impact of health and social care integration on children's services in Scotland. Both reports provide an update on the findings of an extensive study, published in 2014-15, which looked at the potential impact of the Public Services (Joint Working) (Scotland) Act 2014 (the legislation through which health and social care integration has been established in Scotland).

These update reports, like the original study, have been commissioned by Social Work Scotland, and carried out by a partnership of Children in Scotland and CELCIS (Scotland's Centre of Excellence for Looked After Children, based at the University of Strathclyde), with input from the Care Inspectorate. Their aim is to inform and stimulate debate about health and social care integration in Scotland, and public sector reorganisation more generally, highlighting in particular how this policy agenda is affecting the planning, management and delivery of children's services.

We are very grateful to Healthcare Improvement Scotland (HIS) for providing the funding that enabled these update reports to be completed.

Introduction

A comprehensive literature review on the potential effects, on children and family services, of the Public Services (Joint Working) (Scotland) Act 2014 (from herein, 'the Act') was published in 2014 (see Welch, McCormack, Stephen, & Lerpiniere, 2014). That review provided a summary of international progress and debate around service integration and highlighted issues pertinent to Scotland's planned approach to health and social care integration. The review concluded, for example, that integration at locality level had been shown to be effective in improving the accessibility of services, but that revised organisational and financial structures, often involving 'pooled budgets', were required to sustain such arrangements. In addition, the report underscored the barriers to integration, including inter-professional communication difficulties, IT systems, and financial resources.

> *"[…] when a young person with a disability turns 18 and faces a lack of coordination between children's and adult services, the result is always damaging, distressing and counterproductive. There may be financial and organisational costs, but the main impact of poor integration is human."*
> *(Glasby, 2014, p.1)*

In relation to children, young people, and families, the original literature review explored how changes to adult health and social care services could have implications for four groups: (i) young people transitioning to adult services, (ii) young carers, (iii) care leavers, and (iv) vulnerable children, whose parents are in receipt of adult services, such as mental health support, or drug and alcohol services. The review concluded that, while the integration of adult health and social care in Scotland was likely to impact on these groups of children and young people, there was the potential for that impact to be positive if children and young people's specific needs were properly considered in local service planning and delivery.

This document provides an update to that original literature review. Nearly three years on from the commencement of the Act, we take this opportunity to reflect on how the needs of Scotland's children and young people have been taken into consideration throughout the early implementation of health and social care integration in Scotland. With public service integration a key policy agenda across Europe, new research has become available, providing further insight into public service integration's strengths and weaknesses, its enablers and barriers. Since the publication of the original literature review, there has also been a series of joint strategic inspections of services for children and young people, conducted by the Care Inspectorate (in partnership with other relevant scrutiny partners). These inspections provide a valuable source of new information, a summary of which is included below.

Reflecting on this range of new material (published since 2014), this Literature and Policy Review builds on the original report's conclusions. It highlights the importance of quality local leadership at all organisational levels, the need for greater attention to the synergies of health and social care strategic plans and Children's Services Plans, and a continued focus on 'bottom up', person-centred, community-led approaches to integration.

Methodology

Our approach to this updated review has been flexible and pragmatic, including any relevant peer-reviewed articles and grey literature sources (such as policy and practice reports, conference proceedings, legislation and guidance, inspection findings) published since 2013-14. Members of the research team have read the material, analysed and summarised information, and extracted the key themes and findings. The review presents this material in the following sections:

i. Development of legislation, policy and guidance
ii. Recent research on health and social care integration
iii. Insights from Joint Strategic Inspections of Services for Children and Young People

In gathering together relevant academic and policy material for this report, the research team used the following search strategy:

- Approaches to relevant partners and stakeholders for recommendations
- Searches of academic databases, including Scopus and Google Scholar
- Searches through article and report reference lists
- Identification of podcasts, blogs and multi-media presentations
- Online searches though generalist search engines, such as Google and Internet Explorer.

Our aim was to identify material of good quality, the content of which was pertinent to the Scottish context. For this report, we define 'quality' as information with a reliable and trustworthy source, or material that was produced using robust methods of data collection and analysis. In terms of podcast or multi-media material, these were only included if they had come from a reliable source (e.g. Scottish Government, or the Kings Fund). We also prioritised 'Scotland' in the searches, but unfortunately research and non-governmental information continues to be scarce (as the previous review found), we then concentrated on material relating to integration in the UK, and then international evidence.

As in the previous review published in 2014, we use the generic term 'service user' for the sake of simplicity; it is not our intention to infer service users are passive recipients.

Development of legislation, policy and guidance in Scotland

The integration of Scottish public services is a policy agenda with deep roots and multiple drivers. During the 1980s and early 1990s growing demand and rising costs led to calls for more 'joined up' services, with an emphasis on securing efficiency. In the late 1990s the policy discourse shifted, with the objectives of integration presented as quicker decision making and service improvement. Across Scotland various structures and systems developed, on a voluntary basis, to facilitate partnership (focused primarily on services for older people) between local authorities and the NHS.

Eager to accelerate the rate of cooperation and joint strategic planning, the Scottish Government introduced the Local Government (Scotland) Act 2003 (establishing Community Planning Partnerships) and in the following year the National Health Service Reform (Scotland) Act 2004 (mandating the creation of Community Health Partnerships). However, these statutory structures did not deliver the central policy objective of 'integrated' working; particularly in respect of the experiences of service users. Indeed the need for 'integration from the perspective of the service user' was one of the over-arching conclusions of the Christie Commission, set up by the Scottish Government in 2010 to consider how public services should be delivered in the future. It recommended extensive reform of the public sector, with services orientated decisively towards prevention (rather than crisis response), and being planned and commissioned strategically in a partnership between the public, private and third sectors [1].

Statutory requirements in Scotland

The Public Bodies (Joint Working) (Scotland) Act 2014 ('the Act'), and its associated regulations, provide the legislative framework within which Scotland's adult health and social care services are endeavouring to realise the Christie Commission's vision. In summary, the legislation requires NHS Boards and local authorities to integrate the governance, planning, and resourcing of adult social care services, adult primary care community health services, and some hospital services [2]. The hospital services to be integrated are all those not exclusively provided for children. This includes accident and emergency, general medicine (GPs), geriatric medicine, addiction and substance dependency, some mental health services, etc. (Burgess, 2016, p.5). The legislation allows NHS Boards and local authorities to integrate other areas, such as children's health and social care services, at their discretion.

Integration Authority

To facilitate the process of joint strategic commissioning, the local authority and health board must delegate a range of functions to an 'Integration Authority' (Scottish Government, 2014b). These Integration Authorities (also sometimes known as health and social care partnerships) are jointly accountable to Scottish Ministers, local authorities (i.e. elected councillors) and NHS Board Chairs for the delivery of nationally agreed outcomes (Burgess, 2016, p5; Scottish Government, 2016).

Scottish Integration Authorities can take one of two forms:

i an entirely new corporate body called an 'Integration Joint Board', to which the local authority and NHS Health board delegate budgets and authority. The Integration Joint Board assumes responsibility for planning and resourcing health and social care services in the local area. Integrated Joint Boards are not expected to directly employ staff, but can set up committees (involving staff from the local authority, NHS Board and others) to oversee the management of particular aspects of integrated working. The professionals delivering services (e.g. doctors, social workers, etc.) are not required to change employer, or change their employment terms and conditions (Burgess, 2016, p.6).

ii a 'lead agency' model, where the local authority or NHS Health Board delegates relevant powers and responsibilities to the other, so that one agency takes a lead in planning and delivering integrated services in their area. This model does require staff to transfer to either the council or NHS Board (depending on which takes the lead), and potentially a change to employment terms and conditions.

1 For further background on the development of health and social care integration policy in Scotland, please see the original literature review for this study: Welch et al (2014) Integrating Health and Social Care in Scotland: Potential impact on children's services. Report One: A Review of Literature, CiS & CELCIS.

2 The functions that must be delegated are set out in the following regulations: The Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014 and The Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Regulations 2014.

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Local authorities and NHS Health Boards were required to submit draft integration schemes to Scottish Ministers for approval by April 2015, setting out in detail the shape and form of their proposed Integration Authority (i.e. explaining what functions would be delegated, and how).

As per the legislation, these integration schemes had to be fully implemented by 1 April 2016. Thirty-one Integration Authorities were established. Thirty adopted the Integration Joint Board model, with Stirling and Clackmannanshire local authorities working with NHS Forth Valley to form one Integrated Joint Board. Only Highland chose the 'Lead Agency' model. Within the 'Highland Partnership', Highland Council is the lead agency for children's community health and social care services, and NHS Highland is the lead agency for adult health and social care services (Burgess, 2016, p.9).

The legislation also requires each Integration Authority to establish at least two 'localities'. These are supposed to provide an organisational mechanism for local leadership of service planning, to feed up into the overarching Integration Authority. The localities must bring together representatives from relevant professional groups, the third and independent sectors, carers and patient representatives, and people managing services (Scottish Government, 2015). The intention of 'localities' is that these groups have real influence over how resources in their area are spent (Burgess, 2016, p.11). Audit Scotland have noted the wide variation in the number and size of localities between Integration Authorities; Edinburgh, with a population of approximately 120,000, has four localities, while Shetland, population of approximately 4000, has seven localities (Audit Scotland, 2015).

Chief Social Work Officer Role

Under section 3 of the Social Work (Scotland) Act 1968, every local authority is required to appoint a Chief Social Work Officer (CSWO). The role provides strategic and professional leadership in the delivery of local social work services (IS, 2017, p3). Among their duties, the CSWO is expected and empowered to:

- Support overall performance management, and the management of corporate risk.
- Assist the local authority and its partners in understanding the complexities and crosscutting nature of social work service delivery.
- Raise concerns directly with chief officers and elected members.
- Take decisions to curtail an individual's freedom, for the protection of themselves or the public.

Irrespective of which services are included into local integrated arrangements, the CSWO role, and its associated duties, continue to apply across all social work functions delivered in their local area (i.e. both in the Integration Authority and in the council). The CWSO is therefore required to sit as a non-voting member on the Integration Joint Board (or the Integration Joint Monitoring Committee, for Lead Agency areas). Scottish Government guidance [3] also sets out a clear expectation that CSWO have a defined role in clinical and care governance systems, and that they are included in all relevant strategic and operational forums that support the chief officers and elected members within the Integration Authority (IS, 2017). However, the responsibility for appointing a CSWO cannot be delegated to an Integration Authority, and must be exercised directly by the local authority itself.

Strategic Commissioning Plans

On 1 April 2016, Scotland's thirty-one Integration Authorities assumed responsibility for over £8 billion of health and social care spending. Commentators have described this as the most significant shift in the Scottish public sector since the establishment of the Scottish Parliament in 1999 (Bate, 2017, p.30).

To ensure these resources are allocated in a way best designed to achieve the Scottish Government's 'National Health and Wellbeing Outcomes', [4] the legislation requires each Integration Authority to establish a strategic planning group, to support the development and review of a Strategic Commissioning

3 Scottish Government (July 2016) The Role of Chief Social Work Officer: Guidance issued by Scottish Ministers, Edinburgh

4 http://www.gov.scot/Topics/Health/Policy/Health-Social-Care-Integration/National-Health-WellbeingOutcomes [website accessed on 3 October 2017)

Plan (sometimes referred to as the 'Strategic Plan'). The plans include information about the services that will fall within the remit of the Integration Authority, and the financial resources available to them. Referring to the Strategic Planning process, the Scottish Government's Integrated Resource Framework Lead, Paul Leak, stressed that:

> *With the full involvement of all stakeholders, partnerships have the chance to start with a blank sheet of paper and think innovatively about how services might be provided in the future. It should be less about how it is done now and more about how it should be done in the future. This might mean disinvesting in current provision to reinvest in alternative arrangements.*
> *(Leak, 2016, slide 22)*

Strategic Commissioning plans must be prepared with regard to the 'Integration Delivery Principles' [5] (see Box 1 below) and each plan must be reviewed at least once every three years (Scottish Government, 2014a, 2015). Alongside the Strategic Plan, each Integration Authority must also publish an Annual Financial Statement, detailing how they will allocate resources to achieve the National Health and Wellbeing Outcomes (see Box 2 below). A new financial statement must be published each year (Scottish Government, 2015, p.22).

Annual Performance and Financial Reporting

Every Integration Authority is also required to prepare and publish an annual performance report on, among other things, how the arrangements in the strategic plan are contributing to the achievement of the National Health and Wellbeing Outcomes. The annual report must also set out the actual use of resources across care groups, localities, and service types, comparing these with what was set out in the plan. Through this detail, Integration Authorities must explain how implementation of their strategic plan, over the previous year, has contributed to the Integration Authority achieving 'best value' (Scottish Government, 2015).

Box 1: Health and Social Care 'Integration Delivery Principles'

- That the main purpose of services which are provided to meet integration functions is to improve the wellbeing of service-users.
- That, in so far as consistent with the main purpose, thise services should be provided in a way which, so far as possible:
  - Is integrated from the point of view of service-users
  - Takes account of the particular needs of different service-users
  - Takes account of the particular needs service-users in different parts of the area in which the service is being provided
  - Takes account of the particular characteristics of different service-users
  - Respects the rights of service-users
  - Takes account of the dignity of service-users
  - Takes account of the participation by service-users in the community in which service-users live
  - Protects and improves the safety of service-users
  - Improves the quality of the service
  - Is planned and led locally in a way which is engaged with the community (including particular service-users, those who look after service-users and those who are involved in the provision of health and social care)
  - Best anticipates needs and prevents them arising
  - Makes the best use of the available facilities, people and other resources.

5 As set out in section 31 of the Public Bodies (Joint Working) (Scotland) Act 2014, and explained in Scottish Government (2015) Strategic Commissioning Plans Guidance, p.15

National Health and Wellbeing Outcomes

The statutory framework for health and social care integration makes local Integration Authorities accountable for achieving a prescribed set of 'National Health and Wellbeing Outcomes' (Scottish Government, 2014a). This distinctive feature of the Scottish legislation is an explicit attempt to focus effort on impact, rather than structures and inputs alone. These outcomes also provide a useful performance management/ accountability tool, applicable across all Integration Authorities.

Box 2: National Health and Wellbeing Outcomes

1 People are able to look after and improve their own health and wellbeing and live in good health for longer
2 People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
3 People who use health and social care services have positive experiences of those services, and have their dignity respected
4 Health and social care services are centered on helping to maintain or improve the quality of life of people who use those services
5 Health and social care services contribute to reducing health inequalities
6 People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing
7 People using health and social care services are safe from harm
8 People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
9 Resources are used effectively and efficiently in the provision of health and social care services.

In addition to these national outcomes, the Scottish Government has published a 'Core Suite of Integration Indicators' (set out in Appendix A below). These were developed in partnership with local authorities, NHS Health Boards and the third and independent sectors, drawing together measures that provide an indication of progress towards the outcomes (Burgess, 2016; Scottish Government, 2015). The indicators fall into two types of complimentary measures: (i) indicators based on survey feedback (from service users), emphasising the importance of a personal-outcomes approach; (ii) indicators derived from organisational/system data.

Support in implementation

Along with a suite of guidance, toolkits, and advice notes [6], the Scottish Government has made funding available for workforce education and development. 'Each [national] outcome has a programme of activity to support the health and social care workforce, which includes the development of an e-learning resource to support joint strategic commissioning' (Bruce & Parry, 2015, p.45).

In addition, a partnership between the Scottish Social Services Council (SSSC), Royal College of General Practitioners, and NHS Education Scotland led to the development of 'Leadership for Integration'. This programme consists of two complimentary courses, aimed at GPs, senior health care professionals, and senior managers in statutory, third or independent organisations working in health and social care partnerships. The programme's aim is to build the leadership skills and capabilities to operate effectively in integrated arrangements (Bruce & Parry, 2015, p.45).

Integration Authorities & Children's Service

While Scottish legislation does not require local authorities and NHS Health Boards to integrate 'children's services' (i.e. services used exclusively by those under 18 years old), all Integration Authorities

6 Guidance and advice notes are available through the Health and Social Care pages of the Scottish Government website: http://www.gov.scot/Topics/Health/Policy/Health-Social-Care-Integration/Statutory-Guidance-Advice

hold some responsibility for services used by children and young people (Burgess, 2016). This is because many health services included within integration schemes are not age specific (e.g. A&E, primary care and general dental services), both children and adults use such services.

However, nineteen Integration Authorities have chosen to go further, explicitly and formally integrating some 'children's services' under their Strategic Plan. [7]

Of these, eight have included all or part of children's health services into their integration scheme:

Integration Authorities responsible for children's health services
East Lothian
Midlothian
Fife
Renfrewshire
South Lanarkshire
Western Isles
Dumfries & Galloway
Shetland

Another eleven have included some children's health and social work services:

Integration Authority/Area	Children's health services included	Children's social care services included
Argyll and Bute	All children's health services (including all hospital services)	Children and Families Social Work
East Ayrshire	Community Children's Services Community Infant Feeding Services Child and Adolescent Mental Health Services Family Nurse services	Children and Families Social Work
East Renfrewshire	Health Visiting School Nursing Child and Adolescent Mental Health Services Community children's services	Children and Families Social Work
East Dunbartonshire	Health Visiting School Nursing Children's specialist services	Children and Families Social Work
Glasgow	Health Visiting School Nursing Children's specialist services	Children and Families Social Work
Highland (Council)	All children's health and social care functions	
Inverclyde	Health Visiting School Nursing Child and Adolescent Mental Health Services Community children's health services	Children and Families Social Work
North Ayrshire	Community Children's Services, Community Infant Feeding Service Child and Adolescent Mental Health Services Family Nurse	Children and Families Social Work
Orkney	Health visiting Family Health Service	Children and Families Social Work
South Ayrshire	Community Children's Services, Community Infant Feeding Service Child and Adolescent Mental Health Services Family Nurse	Children and Families Social Work
West Dunbartonshire	Health Visiting School Nursing Child and Adolescent Mental Health Services Community children's services	Children and Families Social Work

7 Scottish Government (22 February 2017) Health and Social Care Integration – Chief Officers [webpage accessed 14 November 2017]

None of the 'National Health and Wellbeing Outcomes' or 'Integration Indicators' mention children and young people specifically, but the Strategic Plans for the eleven Integrated Authorities (in the table immediately above) all set out explicitly which parts of children's health and social care services will be integrated, and how. All of the plans also include, in addition to the National Health and Wellbeing Outcomes, the three child-focussed outcomes from the Scottish Government's National Performance Framework [8]. These are:

- Our children have the best possible start in life and are ready to succeed.
- Our young people are successful learners, confident individuals, effective contributors and responsible citizens.
- We have improved the life chances for children, young people and families at risk.

The plans all make a positive case for the inclusion of children's services in the integrated arrangements. For example, Glasgow's Strategic Integrated Plan describes it as 'an ideal opportunity to strengthen collaboration, develop a cohesive partnership and ensure the most significant impacts to improve outcomes' (GCIJB, 2015).

Connections to children's services planning and improvement

One reason why only eleven local areas have taken the opportunity to integrate children's services is the planning and accountability challenges that integration potentially creates for local partners. For example, local authorities and NHS Health Boards which choose to integrate children's services must still develop a Children's Services Plan for their local area (A. Taylor, 2015b). Under the legislative provisions of Part 3 (Children's Services Planning) of the Children and Young People (Scotland) Act 2014, local authorities and NHS Health Boards are required to work together in the planning, deliver and review of all 'children's' and 'related services', publishing a three year strategic plan.

'Children's services' are defined as any service available in the local area provided wholly or mainly to, or for the benefit of, children by the local authority, the local NHS Health Board, any 'other service provider', and Scottish Ministers. This includes, but is not restricted to, children's social work, health and education services. 'Relevant services' are defined as any service provided in a local area which, though not a children's service, is capable of having significant effect on the wellbeing of children (Scottish Government, 2016, p.16). This is likely to include services made available to adult parents and carers.

The Children's Services Planning partners (local authorities, NHS Health Boards, and other specified local and national partners) must prepare their plan in reference to statutory 'Children's Services Planning' aims [9], and involve a wide range of stakeholders in the plan's development, delivery, and review. The partnership must also publish performance reports each year, profiling their progress on securing the aims and objectives set out in their Children's Services Plan. These legal requirements closely mirror those placed on Integration Authorities by the Public Bodies (Joint Working) Act 2014.

In addition to this, the Education (Scotland) Act 2016 also requires all education authorities (i.e. local authorities) to prepare and publish annual plans, describing how they will deliver on the aims and objectives of the National Improvement Framework for Scottish Education. These annual plans must describe the steps the authority intends to take to reduce the inequalities of outcome experienced by pupils as a result of socio-economic disadvantage, and, the ways in which they will consult key partners when deciding how this should be achieved (Scottish Government, 2016, p.72). To achieve both the letter and aims of this law, education authorities will need to consult and collaborate heavily with children's social work services and their local NHS Health Board.

At the wider community level, Part 2 of the Community Empowerment (Scotland) Act 2015 places a range of other duties on Community Planning Partners, designed to strengthen the collaboration of public bodies and local communities in planning. Among the new duties, the Community Planning Partnership is required to

8 Scottish Government's National Performance Framework: http://www.gov.scot/About/Performance/purposestratobjs

9 Section 9, Part 3, Children and Young People (Scotland) Act 2014

prepare and publish a 'local outcomes improvement plan' which sets out the local outcomes the partnership has prioritised for improvement. In preparing the plan, the CPP is obliged to make all reasonable efforts to secure the participation of community bodies in the planning process. The plan also has to set out 'how' the partnership will deliver the improvements in local outcomes, detailing the resources which will be deployed (Scottish Government, 2016, p.66).

Also relevant are the new duties of 'corporate parents'. Part 9 of the Children and Young People (Scotland) Act 2014 designates certain public bodies (including all local authorities and territorial NHS health boards) as corporate parents, and places them under a range of duties designed to safeguard and promote the wellbeing of looked after children and care leavers. Each corporate parent is required to prepare (either independently or in collaboration with another corporate parent) a plan about how they propose to exercise their corporate parenting duties, and they must keep that plan under review. Corporate parents are also under a duty to report how they have exercised their corporate parenting duties. These reports may include information about standards of performance, and the progress achieved in securing positive outcomes for the eligible population (Scottish Government, 2016, p.71).

While the relevant Scottish Government guidance acknowledges that links exist between these interrelated improvement agendas, they have not, to date, specific exactly what those links are, or how they should be managed operationally. Instead local areas have been afforded discretion to determine how these components of public sector reform should fit together; deciding, for instance, whether the 'Health and Social Care Strategic Plan' or 'Children's Services Plan' takes priority in terms of time and resources.

Summary – Legislation, Policy and Guidance

The aims and approach to improvement mandated by the Children and Young People (Scotland) Act 2014 are very similar to those mandated by the Public Bodies (Joint Working) (Scotland) Act 2014. To improve outcomes for people in Scotland by ensuring local planning and delivery of services are integrated, focused on securing quality and value through preventative approaches, and dedicated to safeguarding, supporting and promoting wellbeing. The Education (Scotland) Act 2016 and corporate parenting duties, while narrower in their focus, also feature a logic of collaborative planning and regular performance monitoring.

However, in creating these parallel structures, with little reference or explicit connection made between them in legislation or guidance, it is possible that their individual potential for improving people's lives is diminished. Either through the fragmentation of children's services (with parts in Integration Authorities and others in Community Planning Partnerships) or because the 'whole system' improvement opportunities which can come from bringing adult and children's services together is made more difficult, by situating planning and resourcing in different structures. This concern has been noted elsewhere, particularly in relation to mental health services for children (Audit Scotland, 2015; Stephen, Lerpiniere, Young, & Welch, 2015: para 61), and it is alluded to in the Scottish Government's Statutory Guidance on Part 3 (Children Services Planning):

> *'[…] whatever the integration of functions at a local level, there will always need to be communication between these two planning domains [health and social care integration and children's services planning]. From the perspective of children's services planning, the adult health and social care context is important because most children live in families with adults. Adult family members' access to, and the quality of, health and social care services, is likely to have an effect on the wellbeing of children and young people. Similarly, for the providers of adult health and social care services, children and young people represent future service users. As part of their longer term planning strategy, integration authorities will need to work with the relevant local authority and health board to monitor the health and wellbeing of the child population in the area, understanding needs, identifying potential issues and, with partners, putting in place appropriate preventative actions.' (Scottish Government, 2016, p.69)*

The role of legislation in driving integration forward is widely seen to be crucial (Hendry, Taylor, Mercer,

& Knight, 2016; Humphries, 2015; A. Taylor, 2015a, 2015b). However, operating multiple, statute-driven integration and collaboration agendas at same time, as is currently the case in Scotland, may create tensions and complications that do not benefit local populations. Stephen et al. (2015: para 74), among others, has highlighted the challenge of achieving the changes necessary to make integration successful amid 'a raft of game-changing legislation and policy' (see also Audit Scotland 2015 & 2016).

In an early review of the Public Bodies (Joint Working) Act's implementation, Audit Scotland (2015) made a number of observations which have implications for the various children's services improvement efforts now underway. Among these were:

- Confusing lines of accountability and potential conflicts of interests, hampering the ability of Integration Authorities to make decisions about the changes involved in redesigning services.
- People are unclear about who is ultimately responsible for the quality of care.
- Slowness to shift resources, including the workforce, towards a more preventative and community-based approach.

These concerns were reinforced in a 2016 report from Audit Scotland, entitled 'Social Work in Scotland'. This stated that current approaches to delivering social work services are not sustainable in the long term, and cast doubt on social work department's ability to respond to today's challenges. Reductions in public spending at a time of increasing demand is creating significant pressure for social work services, but Audit Scotland also drew attention to governance issues, particularly when services (and their planning and budgets) are split between Integration Authorities and local authorities (Audit Scotland, 2016, p.39). Furthermore, the report observed that CSWOs may become overstretched and undervalued within the new integrated arrangements, damaging their ability to maintain professional standards (Audit Scotland, 2016, p.42).

Across children's and adult services, there is a coherent and consistent theory of change behind the Scottish Government's reform agenda, based on greater integration, shared ownership, service user participation, and regular, robust performance monitoring. But it is a busy and complicated policy landscape, with multiple, overlapping agendas in place. This is potentially stretching the capacity of leaders, service managers, operational staff, and even communities, to commit fully to the changes needed. In September 2017 the Scottish Government announced that regional collaboratives will be introduced to facilitate school improvement, adding a further layer to local planning, administration and governance arrangements. In the context of such extensive and continuous change, it is possible that public service reform is itself becoming a barrier to public service improvement.

Recent research into health and social care integration

International developments around health and social care integration continue to drive a range of research outputs. In the main these are evaluations of relatively small scale pilots, or discussion pieces on the progress of national, regional or local policy implementation (Cameron, Lart, Bostock, & Coomber, 2014; Johnston, Rozansky, Dorrans, Dussin, & Barker, 2017; Kaehne, Birrell, Miller, & Petch, 2017; Luckock, Barlow, & Brown, 2017; Winters, Magalhaes, Kinsella, & Kothari, 2016). There continues to be a lack of in-depth, comparative research, exploring the impact of public service reorganisation on service user experiences and outcomes across an administrative area. And, given the global policy emphasis on adult health and social care, research continues to focus on issues related to care for older people, with little or no reference to children, young people, or families.

However, recent research does provide insights that are of relevance to Scotland's ongoing development of health and social care integration, and its impact on children's services. The section below draws out some of the key findings from recently published literature, grouped into themes. (Please note the material below relates only to research published since 2014; for a full overview of the available literature on health and social care integration, this report should be read alongside our 2014 publication: *Integrating Health and Social Care in Scotland: Potential impact on children's services. Report One: A Review of Literature).*

1 Impact on services for children and young people

The literature presents a mixed picture in relation to health and social care integration's impact on children and young people. Frost, among others, notes the growing evidence that 'multi-professional working can have a positive effect on outcomes for children and young people' (Frost, 2017, p.343). Others have highlighted how integrated programmes of intervention, in areas such as substance misuse or domestic violence, are effective, in part, because they explicitly address parental and child needs together, at the same time (Calhoun, Conner, Miller, & Messina, 2015; Howarth et al., 2016).

A review of child health studies concluded that, while inter-agency collaboration was generally perceived as helpful and important by both service users and professionals, with collaborative initiatives often evaluated positively, significant barriers limited progress towards making it part of day-to-day practice. These barriers included inadequate resourcing, poor inter-agency communication, a lack of valuing and understanding colleagues across professional boundaries, and data sharing issues (Cooper, Evans, & Pybis, 2016). Other research has also found that service providers still do not, in general, take the voice of children and young people as seriously as adult patients (Kossarova, Devakumar, & Edwards, 2016). The authors suggest this might explain the discrepancy in the proportion of budgets allocated to children's services and the actual level of need among the child and young person population (ibid, p.15).

Kaehne (2016), reporting preliminary findings from a longitudinal study of an integrated care programme for children in an urban setting in the north of England, notes that commitment and enthusiasm for collaborative work was initially high amongst professionals, and remained so throughout the first year. But as time progressed, study participants (professionals) expressed significant scepticism about the problem solving capacity of multi-agency work, and pessimism about the integration programme's ability to improve service quality and service outcomes. This pessimism was particularly pronounced among staff from non-NHS organisations. In identifying barriers to successful integrated working, Simpson and colleagues point to the 'them and us' mentality which continues to exist between different professional groups (Simpson et al., 2016). Kaehne concludes too that 'the skin-deep character of many integration efforts [may be] unable to challenge or transform organisational cultures and sectoral fragmentation' (2016, p.2). Professionals often appear to view organisational structures as immutable, and an integration programme's transformational capacity therefore depends on factors such as leadership.

Looking specifically at integrated working around child protection, a number of reports have drawn clear links between the strength and extent of inter-agency collaboration and the efficacy of systems and practice. In Lewis et al's 2015 study of partnership between social work and acute healthcare professionals, the researchers found that, for collaboration to be effective, a shared vision had to be in place. A vision that was 'clearly articulated and evident in working practices, protocols and pathways, and visible in strong professional relationships with and between agencies' (Lewis et al., 2015, p.310). Narrow, process-led, top-down approaches to collaboration were unlikely to improve joint working. Reaching similar conclusions, inspectors from OFSTED and the Care Quality Commission observed that drug and alcohol services (in England) consistently made timely and appropriate referrals when concerns about children emerged, unlike adult mental health services, where issues were not always being recognised, or referrals made. The inspectors suggest this is due to better understanding, communication and engagement between adult drug and alcohol professionals and children's social care services (Lewis, Greenstock, Caldwell, & Anderson, 2015; OFSTED, 2014).

In relation to care-experienced young people, recent research reinforces a well-established picture of disjointed services, with too little attention paid to the transition points; leading to challenges when individuals move within and out of the care system (SCIE, 2013). The need for professionals to work more collaboratively is frequently emphasised, with the goal of improving coordination of services and the continuity of interactions. Looking specifically at mental health, evidence from a 2016 study suggests that, on the basis of care-experienced people's reflections, access to services which span the social care transition (between children and adult services) make a difference to their wellbeing (Butterworth et al., 2016). The study participants suggest that the key to successful transitions out of care is enabling young people to maintain trust in, and support from, relevant services (Butterworth et al., 2016).

Young people have indicated that it is not just relationships with professionals that are important, but that there is a range of other people from whom they derive support (Winter, 2015). These include family members and friends, some of whom may be involved in adult health and social care services. O'Reilly et al. (2013) note that to facilitate the involvement of parents and children, agencies need to consider how they are communicating with each other, adopting formats and language that are accessible to the service user.

Unfortunately, there is still little research available about the interface of adult and child services. This lack of information on how services integrate in the interests of child and/or adult, often at critical points in an individual's life, and disproportionately for vulnerable service users, is a significant missing piece of the evidence base. Particularly when we consider how much is now known about the connections between parental behaviour and children's outcomes (OFSTED, 2014).

2 Utilising 'bottom-up' approaches

Scotland's 2014 Act aimed to empower communities and front-line professionals to utilise 'bottom-up' approaches in the development and improvement of health and social care services in their local area (Stephen et al., 2015). Research across a variety of integration authorities is now providing evidence on the effectiveness of such approaches, helping to identify their core components (i.e. which aspects of the approach make a difference), and highlight the conditions that need to be in place for approaches to be successful.

For example, a report published by a team from NHS Scotland and the Scottish Social Services Council documents work undertaken with different integration partnerships across Scotland, using 'Appreciative Inquiry' to motivate and involve front-line professionals in the planning and improvement of services (IRISS, 2016). The research concluded that, by applying a positive frame to questions and focusing explicitly on how professionals listen to each other, partnerships came up with new ideas and solutions to local issues. In another report by IRISS, researchers explored how service users can be 'put first' in an integrated practice model through 'co-production' (IRISS, 2015). The project focussed on the development of two service user groups: dementia support, and heart failure support. The service users worked with professionals from the statutory and third sectors, using a co-production approach [10]. The evaluation found that service users developed increased capacity to engage, and that health and social care

10 A co-production approach is a relationship where professionals and citizens share power to plan and deliver support together, recognising that both have vital contributions to make in order to improve quality of life for people and communities (National Co-production Critical Friends Group (undated)).

practitioners across agencies showed increased capacity to understand each other's perspectives, and to work with service users in a collaborative way.

Tsegai and Gamiz (2014), in a Scottish study of the involvement of carers, found their participants to be 'a fountain of knowledge', but noted their expertise was often missing from the planning and delivery of services. In addition, the study found that informal processes of face-to-face conversations rather than paper-based systems were more effective in integrating carers into the process. This relationship-based approach was also emphasised by Taylor (2017), in a reflective article about his experiences as an adult social services manager in a Scottish integration authority. He concludes that 'people and the relationships between them are the critical resource we have in solving the complex problems of this century' (Taylor, 2017, p.10). A similar view emerges from an article on integration from Cook and Harries (2014), which also highlights engaging service users and carers in the management of care as a way to facilitate better integration. The message that emerges repeatedly from the literature is the importance of core practice, at the individual level between professionals, carers and those in need of support, ensuring care is personalised and services coordinated. User involvement is widely considered critical to success.

The Glasgow Centre for Population Health and the Scottish Community Development Centre (GCPH & SCDC, 2015) facilitated an action research and learning programme, across a number of local areas in Scotland, between March 2014 and September 2015. Entitled 'Animating Assets', in four research sites the programme supported the initiation and development of 'asset-based' approaches to improving a range of health and wellbeing issues. The approach focused on having positive conversations about aspects of community life that statistics and research data often miss, and supporting local people and organisations to work together. There was a specific focus in some areas on capacity building for locality-based organisations and improving communication between community and voluntary sector and statutory agencies (GCPH & SCDC, 2015, p.9). Over the duration of the programme, participants and researchers identified positive changes in the test sites, attributable to the asset-based approaches. However, the work also underlined that such approaches require planned and co-ordinated action, investment and commitment. 'They do not just happen' (GCPH & SCDC, 2015, p.64). Despite being widely cited in policy, working in these asset-based ways was still seen as an addition to the 'day job', rather than a core function, which suggests, the researchers concluded, that the time required to work in an asset-based way is not being acknowledged (GCPH & SCDC, 2015, p.61). However, in evidencing the intrinsic value of such approaches, in Edinburgh, where participation of young people was limited, the Animating Assets approach encouraged people to question assumptions they were making about young people's needs, and how best to meet them. As one participant in the research noted:

> *The most important thing … was about how to take that forward in terms of engaging with young people in the community in seeking their views, and trying to make sure what people were doing and trying to do was actually addressing the need (GCPH & SCDC, 2015, p.57).*

A similar insight was at the heart of the *Building Healthier and Happier Communities project* (SCVQ, 2015). This pathfinder (pilot) for a national programme took place in East Dunbartonshire between October 2013 and March 2015, seeking to understand how a change in community capacity can enable prevention at a locality and primary care level. The project did this by shifting resources into third sector and community-based organisations, increasing their capacity, extending their reach and improving their connections. In the published evaluation of the project, the authors note that the project helped statutory and third sector/ community organisations to identify new partnerships and opportunities to work more collaboratively. These changes, the authors suggest, are enabling partners to transform ideas (usually simple) into action (often challenging), and in doing so, supporting people to look after and improve their own health and wellbeing (SCVQ, 2015, p.85).

There is a strong emphasis on service user involvement in integration authorities' strategic plans, and a number of recent reports have documented how 'bottom up' approaches, putting local people at the centre of planning, can actually facilitate integration. Two

studies (Kaehne, 2016; Townsley, Watson, & Abbott, 2014), observe that a live focus on service users maintains professional's support for change, stimulating motivation and enthusiasm. However, the literature also suggests that, despite some promising initiatives and pilots, service user involvement continues to be an ambition, rather than a reality (Ferrer, 2015; Freeman, 2017; Winters et al., 2016); and where the focus on service users is lost, scepticism about the value of the change process grows over time.

3 The importance of leadership

Research continues to indicate that leadership is a critical factor in the success of any change programme; for example, Petch (2014) states that 'the factors likely to have greater impact on the delivery of acceptable outcomes for individuals are those which focus on leadership, on vision, and on context'. In particular, she identifies transformational and distributed leadership facilitated through a 'strong shared vision'. In a 2015 report on health and social care integration, Audit Scotland (2015) emphasised the need for leadership and clear governance arrangements. Other recent studies of cross-professional integration have also emphasised how leadership is a critical enabler of (or barrier to) successful integration (Abendstern et al., 2014; Best, 2017; Stephen et al., 2015; Whitelaw, Topping, McCoy, & Turpie, 2017).

Hutchison (2015), assessing the factors key to successful service integration in Scotland, highlights technical and process issues, such as the terms and conditions of existing staff in newly integrated structures, the engagement of clinical and professional leads in the process, and the synthesis of outcomes in joint planning. However, Hutchison also identifies the adaptive challenges inherent to transformational change, which require those in leadership positions to display considerable skill in influencing and management.

In a 2016 report, Audit Scotland expressed some concern about the lack of leadership in Scotland, in respect to health and social care integration. Although the report highlighted some examples of good work, and promising models of integration in development, it warned that the shift to new models of care was moving slowly (Audit Scotland, 2016). The importance of clear leadership to the success of health and social care integration, and its absence in some cases, are conclusions echoed in the findings of the Care Inspectorate's Joint Strategic Inspections of Services for Children and Young People (for more detail, please see relevant chapter below).

An interesting component to leadership is in relation to the management of budgets, and the ability to realise financial (rather than just structural) integration. A global evidence review published in 2015 found that many barriers to this kind of integration remained, in the form of differing performance frameworks, service priorities and disconnected information systems (Mason, Goddard, Weatherly, & Chalkley, 2015). However, the authors suggest that, even if services can overcome these barriers, integrated funding is not likely to deliver the cost-savings leaders and policy makers are seeking, as integrated care may uncover unmet need.

Various resources to support leaders to manage health and social care integration have been developed across the UK; two recent examples are the Scottish Social Services Council's *Step into Leadership resources* (SSSC, 2014) and the King's Fund's *Systems Leadership* programme for the NHS (King's Fund, 2014).

4 Inter-professional and inter-organisational practice

Strong relationships exist between health and social care professionals in many countries, including Scotland (Stephen et al., 2015). However, the literature continues to identify gaps in inter-professional and inter-organisational working, linking the slow progress on health and social care integration to differences in priority and professional culture (Mann, 2016; Van Noort & Schotanus, 2015). Indeed, some authors question the ability of individuals and organisations to make the necessary shift in the timeframes envisioned for health and social care integration (Dolan & Frost, 2017; Nolte & Pitchforth, 2014). One commentator notes 'the cultural shift needed to break down the silos in which services work hasn't begun to be addressed […] I think the risk is that in the current budgetary climate, mutual suspicion will triumph over cooperation' (Watson [UNISON Spokesperson] as quoted in Freeman, 2016). This risk was reflected in the minutes of the Glasgow City Council's Shadow Integration Board in January 2016, where members stressed that failure to build strong (inter-professional) relationships across the health and

social care partnership would put the whole project at risk (CGCCSIB, 2016).

In terms of developing co-operation between different professional groups, creating opportunities for active exchange and planning is seen as helpful, facilitating cross-professional understanding (Whitelaw et al., 2017). Such opportunities may also mitigate frictions over professional status, and misinterpretations in use of terminology (Scott, Birks, Aspinal, & Waring, 2017; Waring, Marshall, & Bishop, 2015). As Tett notes, overcoming professional silos 'is not a task that is ever truly completed; it is always a work in progress' (Tett, 2015, p.247). Memon and Kinder (2017), in a study of five Community Health Partnerships in Scotland, concluded that partnerships with co-located workers saw more progress than those without co-located workers, in improving inter-professional understanding.

Alongside co-location and opportunities for professional exchange and joint-planning, learning, and development across professional boundaries also continues to be found as important to the success of integration (O'Reilly et al., 2013; Simpson et al., 2016; Winters et al., 2016). Learning together, and in doing so increasing knowledge about other practitioners and their work, strengthens the understanding, connection, and critically, trust between agencies (Best, 2017; Mann, 2016; Segato & Masella, 2017). Ultimately, increasing the range of opportunities for different professionals to spend time together has the major attendant benefit of fostering personal relationships across organisational boundaries; effective partnerships are built on these relationships and integration made real.

5 Data

Robust data collection is widely and consistently identified as important to both the progress and effectiveness (for service users) of health and social care integration. The Scottish Government has itself repeatedly emphasised this point (see Huggins, 2017). In the conference proceedings of *'Shaping the Future: Intelligence for Health and Social Care Integration - A Gathering'* (ISD Scotland, 2016) it is noted that advances are being made through the Health and Social Care Data Integration and Intelligence Project. However, conference delegates also observed that the data remains heavily skewed towards health indicators, highlighting a potential disconnect with the 'outcomes' of strategic integration plans and person-centred (qualitative) outcomes. Cook (2017) comments that this reflects a dilemma, where Government 'seeks to foster an open relationship of transparency and accountability, and drive collaboration through a performance management system that is based on measures and numerical indicators, despite an explicit recognition that public service partners can only contribute to outcomes'. The proceedings from the conference also note that data about the full impact of integration, such as on children's health and wellbeing, is not being considered.

Summary – Recent Research

The recent literature reviewed here suggests that health and social care integration is widely seen as the 'most significant reform of services since the creation of the NHS' (R. Taylor, 2017, p.10), and that such a shift cannot happen overnight (Stephen et al., 2015). The literature identifies positive gains from the process so far, and a sense of optimism about what the changes promise. In particular, the development of more 'bottom up' ways of working, empowering individuals and communities to participate, inform and influence the agenda, is seen as a real strength. As are the spread of initiatives that seek to enhance the professional relationships across the organisations and professionals involved. Models of integration that put an emphasis on the personal (i.e. service users) and good understanding and communication between different professional groups, are best placed to overcome the inevitable apprehension and 'change fatigue' which saps the enthusiasm of practitioners and services users alike (Erens et al., 2015; Memon & Kinder, 2017; Segato & Masella, 2017; R. Taylor, 2017; Townsley et al., 2014).

Reflecting on UK efforts to integrate health and social care services over past years, Glasby (2017) concludes that we have learnt three key lessons. First, beware structural solutions, which tend to look bold but are often accompanied by a fall in professional morale and productivity. This conclusion is supported by a Scotland-focused study published in 2014, in which the authors concluded that an approach to integration which prioritises the merger of structures, rather than the needs of individuals, could actually be detrimental to service users (Stocks-Rankin, Lightowler, & Wilkinson, 2014). The second, related, lesson Glasby identifies

is that it is difficult to integrate at a local level when national systems and programmes are not designed with integration in mind (i.e. workforce development, financing, etc.). Local areas that have developed cross-organisational relationships and new approaches struggle to maintain these as policy priorities change, or come into conflict with each other. Finally, making the case for integration, Glasby notes that 'we have learned the hard way that silo-based approaches don't work for people with complex needs' (2017, p.1); integration may not save a significant amount of money, but it can improve service user experience and make services more person centred.

For integration to be effective in its aim of improving the availability and quality of services, and thereby promoting better outcomes for communities, research and commentary since 2014 suggests (consistent with earlier literature) that integration authorities should:

- Keep the focus of integration efforts squarely on improving the lives of service users and the wider community; enabling service users to shape changes, to be part of the process, sharing their insight and expertise.
- Bring together leadership teams who can address, simultaneously, the technical and adaptive challenges associated with major change processes (addressing specific, boundaried issues (such as contract terms and conditions) at the same time as on-going issues, like staff morale, change fatigue, etc.
- Build trust and understanding between different professional groups and organisations, through shared learning, co-location, and other formal and informal opportunities that encourage the development of relationships.
- Develop data sets that give insight into people's outcomes, not just service inputs and outputs.

In respect of the impact health and social care integration may have on services available to children and young people, Glasby (2017) notes its positive: 'when a young person with a disability turns 18 and faces a lack of coordination between children's and adult services, the result is always damaging, distressing and counterproductive. There may be financial and organisational costs, but the main impact of poor integration is human' (2014, p.1). But, while there is widespread acknowledgement of the need for, and potential of, service integration for children, the continued paucity of research makes it difficult to draw out any substantive conclusions about how to facilitate its introduction, maximise its benefits, or ameliorate its challenges. The few studies available highlight similar themes to those identified in the wider, more generic literature:

- person-centred integration, not just the merging of organisations;
- shared vision (about what is trying to be achieved) between professionals across child and adult services;
- effective communication strategies, which enable collaboration between different professionals, and the engagement of service users and their families;
- close attention paid to the transition points, both between service areas (e.g. from health to social care) and between child and adult services.

These conclusions are consistent with the findings of our original literature review, published in 2014.

Insights from joint strategic inspections of services children and young people

Since the passing of the Public Bodies (Joint Working) (Scotland) Act 2014, the Care Inspectorate and its partners have undertaken twenty-two joint inspections of services for children and young people, and six progress reviews. Seven of these joint inspections, and three of the progress reviews, were carried out between 1 April 2016, the date by which Integration Authorities had to be in place across Scotland, and 1 August 2017 (at the time of writing). This section of the report profiles findings from these inspections and progress reviews, providing an insight into the relationship between health and social care integration and developments in children's services. The findings highlight the importance of local leadership, regardless of the structural arrangements within which service delivery takes place.

Joint Inspection methodology

The Care Inspectorate works in partnership with other regulatory bodies to carry out joint inspections of services for children and young people. Partner regulatory bodies include Education Scotland, Healthcare Improvement Scotland, and Her Majesty's Inspectorate of Constabulary.

In October 2015, the Care Inspectorate published *'How well are we improving the lives of children and young people? A guide to evaluating services using quality indicators'*. This guide for partnerships provides a framework of quality indicators to support self-evaluation and independent scrutiny, leading to service improvement. The quality framework asks six overarching key questions:

1 What key outcomes have we achieved?
2 How well do we meet the needs of our stakeholders?
3 How good is our delivery of services?
4 How good is our management?
5 How good is our leadership?
6 What is our capacity for improvement?

From these questions, ten key areas are identified, and then these are further broken down into twenty-two 'quality indicators'. The current round of joint inspections is evaluating nine of the quality indicators in the framework. Inspection teams score these indicators against a six-point scale, ranging from Level 1 'unsatisfactory' to Level 6 'excellent'. Joint inspection teams also use this framework in their evaluation of an areas' progress against the relevant outcomes set out within the Scottish Government's National Outcomes Framework.

Joint inspection reports offer comment on the effectiveness of children's services planning as a whole and make no distinction between different integration arrangements for the purposes of scrutiny and assurance.

A focus on leadership

In evaluating the quality of services for children and young people, the Care Inspectorate and its partners focus on the experiences of, and outcomes for, children and young people and their families, using the quality indicator framework. There is less focus on the processes and associated structures for services delivery. However, joint inspection teams do take account of governance arrangements, viewed through the lens of leadership in the quality indicator framework, and in particular, through an analysis of its effectiveness within the partnership area.

The relevant overarching question in the quality indicator framework is *'How good is our leadership?'* The quality indicators in relation to this question are:

- Vision, values and aims
- Leadership of strategy and direction
- Leadership of people
- Leadership of improvement and change

The Care Inspectorate publication *'Joint inspections of services for children and young people: a report on the findings of inspections 2014-16'* outlines findings across all aspects of the joint inspections of children's services. It took account of the extent to which partnerships had developed and disseminated a shared vision for children and young people, enabling staff to feel they were working towards a common goal. The report reviewed the effectiveness of collective leadership and direction with regard to addressing challenges and supporting the implementation of the partnership areas' shared vision. Leaders' commitment, communication, and striving for excellence were also considered in support of transformational change.

As part of these considerations, teams reviewed the challenging context within which leaders operate. The report described integration of health and social care as a 'seismic shift' in the way in which services were to be delivered and the strategic and operational responses that would be required through these, and other, changes in legislation. This includes the challenging financial context as detailed in the Audit Scotland report (2016) 'Social Work in Scotland'.

In respect of quality indicator 9.4 (leadership of improvement and change), of the published joint inspection reports to date, three areas were evaluated as 'weak', seven as 'adequate', four as 'good', four as 'very good', and one as 'excellent'. None were evaluated as 'unsatisfactory'. Only three of the joint inspections took place in partnership areas that had decided to integrate children's social work services into the Integration Authority from 1 April 2016. With regard to the quality of their leadership of improvement and change (quality indicator 9.4) the three areas were evaluated as 'weak', 'good' and 'very good' respectively. This suggests that, regardless of the structural context for services delivery, considerable variation in the quality and effectiveness of leadership exists across partnership areas.

Despite the challenges noted above, there were many elements of effective leadership demonstrated in high performing partnerships. These were:

A strong drive and shared ambition

Investment in strategies to tackle inequalities was a key factor identified in sharing a drive to improve the lives of children and young people. Shared ownership of the vision for local services for children and young people was demonstrated and staff were encouraged to innovate in practice.

Direction, evaluation, and oversight

A coherent and agreed direction with appropriate evaluation and oversight of service delivery ensured that learning was shared widely and successes were celebrated. In high performing partnerships, there was a strong and sustained focus on performance management, quality assurance, and self-evaluation.

Widespread implementation of 'Getting it right for every child' approaches

Stronger performing areas were characterised by successful approaches to prevention and early intervention, including effective implementation and embedding of 'Getting it right for every child' approaches. This built on good capacity and high levels of confidence in staff in universal services to enable them to discharge their responsibilities effectively as Named Persons.

Corporate Parenting responsibilities

Areas evidenced tangible improvements in the life chances of looked after children and young people when leaders took explicit responsibility for transforming systems to ensure services met the needs of this vulnerable group.

The knowledge and profile of children's social work services within the integration agenda

In some areas the integration agenda was primarily focussed on urgent concerns around meeting the needs of older people, thereby, lessening the profile of services for children and young people within integrated arrangements. Strong leadership, particularly through the roles of the Chief Social Work Officer and Chief Officer, strengthened the profile of these services.

Excellence in the use of evidence-based performance data

Partnership performance was better where coherent structures supported Chief Officers by providing well-evidenced information and performance data, specifically through frameworks of governance that included an effective child protection committee or corporate parenting board.

Collaborative leadership

A strong correlation was observed between improved outcomes for children and young people and local structures where there was a high degree of collaborative leadership, constructive challenge, and a shared responsibility for addressing issues that arose.

Robust self-evaluation

In all joint inspections, partnerships were undertaking self-evaluation to a greater or lesser degree. The highest performing partnerships demonstrated approaches

that were systematic, robust, and comprehensive and based on reliable data rather than managers' views, and showed where a clear audit trail existed between lessons learned and system or process improvements. Importantly, those partnerships that performed well were also able to record the differences those system or process changes had made.

Engagement and participation of stakeholders

One key factor relating to the highest performing partnerships was taking account of the views of children, young people, families, staff, and other stakeholders in change processes; especially where this occurred before, during, and after that change, including evaluating the impact of any change.

Benchmarking

Finally, the highest performing partnerships were able to benchmark their work against other partnership areas in order to learn and improve. This included staff participation in national fora where they could learn about different or innovative practice elsewhere and consider its applicability in meeting local needs.

Summary – Insights from Joint Inspections

Leadership is widely acknowledged as a key factor in shaping organisational culture, which, in turn, creates committed and motivated teams, able to deliver effective services (Adair, 2010; Jing & Avery, 2008; King's Fund, 2015; Kouzes & Posner, 2007; MacKian & Simmons, 2013; SSSC, 2014). The ten elements outlined above all attest to this, requiring the permission, encouragement, and strength of compassionate, authentic, and collaborative leaders.

A direct link between local health and social care integration arrangements and the strength (or otherwise) of local services for children and young people cannot be definitively established from the self-evaluation and inspection framework. However, it is clear that the strength, effectiveness, and maturity of strategic leadership and partnership working have a tangible positive impact on outcomes for children and young people. Where strong leadership exists, the inspection partners are beginning to see how the benefits of integration can be maximised.

Reflections and conclusions

The Christie Commission (2011) provided a blueprint for the development of Scotland's public services in the twenty first century. To be effective and affordable in the long-term, public services would need to be:

- built around people and communities, their needs, aspirations, capacities and skills, and work to build up their autonomy and resilience;
- work together effectively to achieve outcomes - specifically, by delivering integrated services which help to secure improvements in the quality of life, and the social and economic wellbeing, of the people and communities of Scotland;
- prioritise prevention, reduce inequalities and promote equality; and
- constantly seek to improve performance and reduce costs, and are open, transparent and accountable.

Health and social care integration, as driven by the Public Bodies (Joint Working) Act 2014, is a central part of the Scottish Government's effort to realise this vision. It seeks to deliver improvement in people's outcomes through reforms to structures and systems, bringing organisations – and communities – more closely together in the planning, delivery and evaluation of public services. It is an approach to improvement not restricted to adult health and social care either. The same high-level policy objectives and logic underpin Children's Services Planning, community empowerment and, to an extent, the proposed regional education colloboratives.

Integration is, therefore, a policy agenda with deep roots and many branches. However, while a coherence of approach across the Scottish Government's agenda is welcome, it is still open to debate whether the approach is, or will, improve people's outcomes. The literature reviewed in this report, consistent with the findings of our 2014 publication, rightly notes that such transformational change takes time, and that positive gains from the process so far have engendered a sense of optimism. In particular, the development of more 'bottom up' ways of working, empowering individuals and communities to participate, inform and influence the agenda, is seen as a real strength. So too are the spread of initiatives that seek to enhance relationships

across the organisations and professions involved. But the literature also warns us to be wary of structural solutions, which tend to look bold but are often followed by a fall in professional morale and productivity (Glasby (2017). For integration to be effective in its aim of improving the availability and quality of services, our review suggests that:

- Government and local partners must keep the focus of integration squarely on improving the lives of service users and the wider community; enabling service users to shape changes, to be part of the process, sharing their insight and expertise. Cost savings should be a welcome by-product, not the central purpose.
- Government and local partners should bring together leadership teams who can address, simultaneously, the technical and adaptive challenges associated with major change processes (addressing specific, boundaried issues (such as contract terms and conditions) at the same time as on-going issues, like staff morale, change fatigue, etc.
- Policy and leaders must build trust and understanding between different professional groups and organisations, through shared learning, co-location, and other formal and informal opportunities that encourage the development of relationships.
- Data sets that give insight into people's outcomes, not just service inputs and outputs, must continue to be developed.

What does this mean for children's services? At the time of writing, nineteen Integration Authorities [11] have chosen to integrate some 'children's services' under their Strategic Plan. The findings of recent joint-inspections of children's services do not evidence a direct link between local health and social care integration arrangements and the strength (or otherwise) of local services for children and young people. However, it is starting to become clear that the strength of strategic leadership in a local area makes a measurable, meaningful difference to outcomes. Where strong leadership exists, the inspection partners are now beginning to see how the benefits of integration can be maximised for the wider community (including children and young people).

This finding is corroborated by the wider literature, which frequently highlights the importance of quality leadership at all organisational levels.

While there is widespread interest in the potential of service integration for children and families, our review found little relevant research. The few studies available highlight similar themes to those identified in the wider service-integration literature:

- Integration should be person-centred, not just the merging of organisations.
- There needs to be a shared vision (about what is trying to be achieved) between professionals across child and adult services.
- Effective communication strategies need to be deployed, which enable collaboration between different professionals, and which promote the engagement of children, young people and their families.
- Close attention has to be paid to the transition points, both between service areas (e.g. from health to social care) and between child and adult services.

Other reviews of Scottish health and social integration (e.g. Audit Scotland, 2015) have noted that greater consideration needs to be paid to the synergies between health and social care Strategic Plans and Children's Services Plans. Without this, local areas that have developed cross-organisational, cross-sectoral relationships (i.e. between child and adult services) may struggle to maintain them as policy priorities change.

That prospect is a real one. While it is still not possible, on the available published evidence, to determine the impact of health and social care integration on children's services, it is without doubt that multiple, regulation-driven integration agendas are now underway across Scotland. A coherent, consistent and evidence-based policy approach underpins them all, but at a practical level, there is limited connection between them in legislation or guidance. Indeed the very fragmentation and re-alignment of planning, resourcing and governance structures, while bringing some services more close together, could actually be making improvement elsewhere more difficult. Established

11 Scottish Government (22 February 2017) Health and Social Care Integration – Chief Officers [webpage accessed 14 November 2017]

lines of accountability and responsibility become blurred or marginalised, and the capacity of leaders, many of whom hold strategic and operational roles simultaneously, may become stretched. In the context of such extensive and continuous change, it is possible that public service reform itself becomes a barrier to public service improvement. Health and social care integration continues to hold out real promise for improving children's services, but the connections across agendas must be closely attended to, and people, not processes or costs, kept firmly at the centre of our discussions.

Appendix One: Integration Indicators [12]

Indicators based on survey feedback:

- Percentage of adults able to look after their health very well or quite well.
- Percentage of adults supported at home who agree that they are supported to live as independently as possible.
- Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
- Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
- Percentage of adults receiving any care or support who rate it as excellent or good.
- Percentage of people with positive experience of care at their GP practice.
- Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
- Percentage of carers who feel supported to continue in their caring role.
- Percentage of adults supported at home who agree they felt safe.
- Percentage of staff who say they would recommend their workplace as a good place to work.

Indicators based on organisational data:

- Premature mortality rate.
- Rate of emergency admissions for adults.
- Rate of emergency bed days for adults.
- Readmissions to hospital within 28 days of discharge.
- Proportion of last 6 months of life spent at home or in community setting.
- Falls rate per 1,000 population in over 65s.
- Proportion of care services graded 'good' (4) or better in Care Inspectorate Inspections.
- Percentage of adults with intensive needs receiving care at home.
- Number of days people spend in hospital when they are ready to be discharged. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.
- Percentage of people admitted from home to hospital during the year, who are discharged to a care home.
- Percentage of people who are discharged from hospital within 72 hours of being ready.
- Expenditure on end of life care.

12 Scottish Government, 2015a, p.2

Appendix Two: Strategic Integration Plans which include Children's Social Work Services

Argyll and Bute
http://www.nhshighland.scot.nhs.uk/OurAreas/ArgyllandBute/Documents/SP%202016-2019%20%20Final.pdf

East Ayrshire
https://www.east-ayrshire.gov.uk/Resources/PDF/H/East-Ayrshire-HSCP-Strategic-Plan-Summary.pdf

East Renfrewshire
http://www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=15568&p=0

East Dunbartonshire
https://www.eastdunbarton.gov.uk/filedepot_download/18043/1861

Glasgow
https://www.glasgow.gov.uk/CHttpHandler.ashx?id=33418&p=0

Highland
http://www.nhshighland.scot.nhs.uk/Meetings/BoardsMeetings/Documents/2016/3%20Highland%20Joint%20Partnership%20Strategic%20Plan.pdf

Inverclyde
https://www.inverclyde.gov.uk/health-and-social-care/health-and-social-care-partnership-strategic-plan

North Ayrshire
https://www.north-ayrshire.gov.uk/Documents/SocialServices/nahscp-strategic-plan2016-18.pdf

Orkney
http://www.orkney.gov.uk/Files/OHAC/Reports/Strategic_Commissioning_Plan_2016_2019.pdf

South Ayrshire
http://www.south-ayrshire.gov.uk/health-social-care-partnership/documents/south%20ayrshire%20health%20and%20social%20care%20full%20strategic%20plan.pdf

West Dunbartonshire
http://www.wdhscp.org.uk/media/1597/strategic-plan-2016-2019.pdfREFERENCES

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