Laying the Foundations for an integrated improvement resource

The purpose of this paper is to lay the foundations for an integrated improvement resource which consolidates the improvement support work and capability of Healthcare Improvement Scotland (HIS), the Joint Improvement Team (JIT) and the Quality and Efficiency Support Team (QuEST).

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1. INTRODUCTION

The purpose of this paper is to lay the foundations for an integrated improvement resource which consolidates the improvement support work and capability of Healthcare Improvement Scotland (HIS), the Joint Improvement Team (JIT) and the Quality and Efficiency Support Team (QuEST).

A working title of Integrated Improvement Resource (IIR) is used but this will change in due course once work is completed on the branding of the new offering.

Whilst building on the strengths of the current arrangements, this paper looks to the future and sets out the purpose, principles, scope, and functions which form the blueprint for a completely new offering. Co-design with stakeholders both internal and external to the three existing bodies has been central to our approach.

It is important to be clear up front in these proposals that in addition to supporting improvement work within the integrated health and social care space, this resource will also be the location of a national improvement offering for NHS boards. While the IIR will relate to NHS Boards and Local Authorities equally on matters pertaining to the ‘integrated space’, it will continue to have a wider role with NHS Boards as the national NHS improvement body. This mirrors the relationship that the Improvement Service has with local authorities.

This paper sits alongside a separate report produced by the Quality Improvement Consolidation Governance Advisory Group which sets out proposals for the governance structure needed to provide effective leadership for the IIR.

Further proposals on staffing, transition and risk management arrangements will follow once this foundation paper has been endorsed by the Healthcare Improvement Scotland Board, the Joint Improvement Partnership Board and the Scottish Government’s Health and Social Care Management Board.

The terms ‘NHS Boards and Integration Authorities’ are used henceforth in this paper to encompass NHS Services, Integrated Joint Boards and Health and Social Care Partnerships, which include third sector, housing and independent sector partners where they interface in delivery of health and social care.

1.1 The drivers for change

The shape of Scottish society and the health and care needs of our communities are changing. People are living longer, healthier lives and as the needs of our society change, so too must the nature and form of our public services.

Integration of health and social care is one of Scotland’s major programmes of reform. At its heart, health and social care integration is about ensuring that those who use services get the right care and support whatever their needs, at any point in their care journey. It aims to transform the way health and social care services are provided in Scotland and drive real change that improves people’s lives.

Underpinning the IIR is a firm belief in the compelling evidence for an intentional approach to improving outcomes across public services and the added value of an effective and accessible national improvement support offering.

As NHS Boards, Local Authorities and Integration Authorities sharpen their focus on shared health and wellbeing outcomes it makes sense to join up our conversations about improving quality and outcomes and simplify/facilitate easy access to national improvement support. QuEST, JIT and HIS all have a strong history of working together with their key partners to improve health and social care outcomes for the people of Scotland (See Appendix 5) The changing context of health and social care integration means that it now makes sense to integrate the improvement resources and capacity that reside in these organizations to create a one-stop shop that makes it as easy as possible for Integration Authorities and NHS Boards to access improvement support. Integration of these resources will also help to reduce duplication and enable better co-ordination of the
national improvement offering across health and social care.

In taking this work forward we acknowledge that, once the new resource is established, it will still only be one of a number of organisations in Scotland that have a role to play in supporting improvement in health and social care. Therefore it is key that the new IIR also has a strong focus on working in ongoing collaboration with other key improvement partners and stakeholders.

1.2 Policy context
The plans for an integrated improvement resource sit firmly within Scottish Government’s commitment to achieving the outcomes that matter most to the people of Scotland through Public Service Reform and pursuit of the four ambitions. These are:

- A decisive shift towards prevention;
- A sharp focus on improving performance, through greater transparency, innovation and use of digital technology;
- Greater integration of public services at a local level driven by better partnership, collaboration and effective local delivery;
- Greater investment in the people who deliver services through enhanced workforce development and effective leadership;

The Public Bodies (Joint Working) (Scotland) Act 2014 was granted royal assent on April 1, 2014 and is a key aspect of this Public Service Reform.

The 2020 vision for Health and Social Care and its ‘Route Map’ sets out 12 priorities for action under three domains - Quality of Care, Health of the Population, and Value and Financial Sustainability. Further information on the policy context can be found in Appendix 1.

1.3 Integrated Improvement Offer
Against this backdrop the Cabinet Secretary for Health, Wellbeing and Sport made the following announcement during a Scottish parliamentary debate on 19 March 2015:

“As part of ensuring improvement in the quality of services, we are integrating and enhancing improvement support by bringing together Healthcare Improvement Scotland, the Joint Improvement Team and the Quality, Efficiency and Support Team, and we are providing an additional £2.5 million to support improvement in the new integrated health and social care landscape”

It was agreed that there would be a process led by the heads of the three bodies involved to develop a proposal for the first phase of transition. The following ‘givens’ were set out by Scottish Government:

- There will be an integrated improvement resource that will bring together the improvement aspects of JIT, QuEST and HIS.
- This new integrated improvement resource will harness and build on the unique and common capacities, capabilities and experience of JIT, QuEST and HIS.
- The new integrated improvement resource will be hosted within HIS. The Board has undertaken to make appropriate changes in governance arrangements to support the new integrated offer.

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• The new integrated improvement resource will be fully functional and have its governance in place by 1 April 2016

1.4 What do we mean by improvement?
Across the breadth of health, housing and social care, the concept of improvement is understood in different ways. There has been a healthy debate during this process about the concepts of “improvement” and “quality improvement” and whether they mean the same thing. Going forward, it will be necessary to find a language for the IIR that spans and connects everyone involved in health and social care and their partners from housing, third and independent sectors. This will be a key task for the new resource in its early stages of development.

In this context, ‘The 3-Step Improvement Framework for Scotland’s Public Services’ published in 2013 has merit. This framework sets out the characteristics that must be in place to support transformational change whatever the setting. Importantly, it uses a language that is shared and principles that are evidenced based.

The definitions of ‘quality’ are wide and varied. Essentially it relates to the degree of excellence in health and care services. This excellence is multidimensional and consists of six dimensions of quality; safe, effective, person-centred, timely, efficient and equitable. The versatility of the Six Dimensions of Quality Framework makes it applicable to all service sectors. Moreover, it acknowledges the dynamic complexity of human systems and how intervention in one domain can influence others, both to the negative and the positive.

“It (the new resource) needs to be flexible enough to (start) where people are on their journey.....”

Survey Stakeholder

In setting out the proposals for the IIR it is clear that this is a resource that must be fleet of foot, flexible, responsive and able to adapt within an ever-changing environment. Therefore, these proposals must be seen in that light with an acceptance that what the organisation does and how it does it will need to adapt over time.

2. THE CO-DESIGN PROCESS
Throughout, there has been a commitment to co-design. The wide range of stakeholders involved in the process - including Scottish Government, NHS boards, Local Authorities, Integration authorities, third sector, independent sector, housing and existing staff in the three bodies - has meant that there has been a wealth of expertise and experience to support the design of the new resource.

Critically, those individuals and organisations who will be the key partners for the new resource were in the forefront of the discussions and design process.

The feedback from this engagement underpins the proposals for the new resource and all of the quotes used throughout this paper are the words of people who were interviewed during the stakeholder survey. Please see Appendix 2 for more detail on this stakeholder survey and the other activities we undertook.

The stakeholder feedback has also been important in helping to identify the risks associated with integrating the three bodies, particularly in relation to concerns about the potential loss of valued services and about improvement and scrutiny sitting together in one organisation. A risk mitigation plan will form part of the transition plan.

In the writing of this paper we also consulted 13 people we considered to be ‘experts’ in their fields with a bearing on the work of the new resource. We are grateful for their time and words of wisdom as they commented on early drafts which will also inform the work going forward.

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1 Scottish Government (2013) The 3-Step Improvement Framework for Scotland’s Public Services, Available online  

2 Healthcare Quality Strategy (IoM Six Dimensions of Quality) quoted in Evidence into Practice Website Available online  
In articulating the new offering, we drew on a wide range of ‘intelligence’ such as evaluations and impact reports relating to each of the integrating bodies. Works are referenced directly where appropriate. In addition a range of theories have influenced our thinking and these are included in a bibliography at the end.

3. THE INTEGRATING ORGANISATIONS
The current role and scope of the bodies being consolidated into the IIR are important considerations when defining the purpose and function of the new resource going forward. The key features of each are set out in Appendix 3.

The added value of the three bodies coming together can be summed up best in the words of one of our stakeholders.

"The value of a single voice = a more collective voice across Scotland, helping us prioritise what improvement activities to undertake. It’s about connecting – currently we all talk to different stakeholders."

Survey Stakeholder

The next sections set out the proposals for the new resource.

4. FOUNDATION FOR THE INTEGRATED IMPROVEMENT RESOURCE

4.1 The Purpose
The ultimate purpose of the IIR is to improve health and wellbeing outcomes for people, families and communities, whilst seeking to reduce inequalities. The IIR will not have a direct role in delivering care. Instead it will support and facilitate NHS Boards, Integration authorities and their partners to improve quality of care/support with the ultimate aim of improving health and wellbeing outcomes for their populations. It will do this by:

a) Facilitating and supporting organisations and teams to transform and redesign the care and support they provide with individuals and communities
b) Supporting the development of cultures of continuous improvement at every level of care and support provision.

In delivering these aims, the new Integrated Improvement Resource will maintain the principle that engagement is voluntary.

4.2 Guiding Principles
Building on the strengths and experience of the integrating organisations, and drawing on innovative ideas and best practice in improvement, eleven guiding principles have been developed. These principles, which we refined following feedback from our stakeholders during the engagement events, create the framework within which the IIR will work.

1) Focus on the experience of people, families and communities as a foundation to underpin all improvement work.
2) Be co-designed, co-owned and co-delivered with NHS Boards and Integration Authorities alongside broader interests in community, housing and third sector.
3) Focus on place and locality, and look at people’s whole experience rather than silos of service delivery organizations.
4) Deliver interventions in a manner that works with rather than does to with the aim of building local improvement capacity, which over time will become more self-sustaining.
5) Support clinicians, professionals and managers to work together with those who receive services, recognizing that aligning behind a common improvement goal significant increases the pace and sustainability of any improvement work.

6) Be outcome-focused using quantitative and qualitative data to demonstrate impact.

7) Understand the importance of both systems thinking and the role of individual relationships within those systems.

8) Focus on adding value by bringing together those elements which are not efficient or viable for NHS Boards and Integration Authorities to do for themselves.

9) Respect the roles of national and local government in providing leadership and direction, whilst placing the engine room of improvement support outside of government.

10) Support localities to understand and address their local improvement opportunities.

11) Endeavor to practise what it promotes in a commitment to continuous quality improvement in all that it does.

“If this is to be an improvement organisation it needs to keep looking at its own offering and to be prepared to stop doing things as well as develop new services and to innovate.”

Survey Stakeholder

4.3 Scope of Integrated Improvement Resource
Consolidating the three organisations brings together the responsibilities for supporting and facilitating improvement across health, social care and the interface with people’s home and community. The IIR will therefore engage with NHS Boards and Integration Authorities which include the public sector, third sector, housing and independent sector partners where they interface in the delivery of health and social care. This includes improvement support for Joint Strategic Commissioning which is a key part of the process of transformational redesign.

The priorities will be set by the new IIR in dialogue with key stakeholders and in response to emerging themes, issues and policy. Prioritisation will be guided by the founding principles of the new IIR and will be both proactive in terms of identifying opportunities for improvement through dialogue with key stakeholders and reactive, for example in response to scrutiny reports.

4.4 Ways of Working
There are five central tenets that underpin how we will work.

Firstly is our commitment to **coproduction**. Embracing the requirement to coproduce services with people and communities, we will support integration authorities, NHS Boards, the third sector, housing and the independent sector to embed the principles of coproduction, enabling them to deliver the national outcomes for health and wellbeing through:

- Recognising people as assets
- Building capabilities
- Establishing mutually beneficial and respectful relationships
- Supporting peer networks
- Blurring distinctions and boundaries to focus on achieving outcomes
- Facilitating rather than delivering solutions

The second is **people**. There is now growing recognition that whatever legislation, structures and governance arrangements might be in place, it is people, and the way they behave, that can make the difference between successful and unsuccessful change strategies. Those working in a service improvement role are key role models in this respect.
A synthesis of the literature on systems leadership undertaken for the Virtual Staff College, emphasises the importance of ‘a mind set or a way of thinking in addition to a set of technical skills or competencies’. Six dimensions of behaviour were identified in this study which will underpin workforce development in the IIR. These are:

- Personal core values (ways of feeling)
- Observations, ‘hearing’ and perceptions (ways of perceiving)
- Cognition, analysis, synthesis (ways of thinking)
- Participatory style (ways of relating)
- Behaviours and actions (ways of doing)
- Personal qualities (an overarching way of being that forms the essence of both professional and personal style and approach)

Thirdly is the importance of conversation in how it shapes and defines our relationships with stakeholders and internally within the IIR. Methods and data for improvement will have little impact without the ability to build relationships and a shared understanding of outcomes through meaningful dialogue.

The fourth, is that health and social care are delivered within complex adaptive systems and that the intricate interplay of people means that it is often hard to predict with any accuracy the long term impact of interventions across this system. Moreover, improvement is more likely to be achieved and sustained when the impact of interventions are considered within the context of the whole system and when programmes are flexible to adjust approaches in light of ongoing experience and learning.

Finally, that what works in one context will not necessarily work in another and as such will require different approaches to supporting improvement.

4.5 Staffing Model

The integrating organisations all use a combination of permanent staffing and cross sector secondments. They augment this by securing additional expertise on a sessional basis such as through the clinical extension model in HIS, an ‘Associate’ model or by drawing on a broader pool of expertise as in the Joint Improvement Team Action Group. This kind of flexibility will be crucial for the IIR going forward.

4.6 Relationships and Interdependencies

The IIR will be one of a number of bodies with a stake in supporting improvement in health, social care and housing. It will capitalise on the opportunities created through integration by working collaboratively with a wide range of national improvement partners and other organisations. A key part of the transitions arrangements will be to identify the range of organisations, including professional bodies, required to fully realise the potential in facilitating transformation and redesign and ensure effective mechanisms are in place for ongoing collaboration.

“We need to make connections to the other organisations – the Improvement Service; Care Inspectorate, etc. Otherwise there will be a perception out there that the new resource will be taking a health only position.”

Survey Stakeholder

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5. THE CORE FUNCTIONS OF THE IIR

It is proposed that the IIR will focus its work around the following five key functions.

During the extensive engagement with stakeholders and staff we began to scope the more detailed offerings that might sit under these headings. This can be accessed in Appendix 4. It is proposed that finalizing this more detailed offering should be taken forward by the IIR. An overview of what sits within the domain of each function is provided below.

5.1 Creating the Conditions for Improving Outcomes

This function involves supporting NHS Boards, Local Authorities, Integration Authorities and partners from other sectors to identify the key enablers and barriers to improvement to create contexts which support sustained delivery of improved outcomes. By encouraging conversations that transcend boundaries, the IIR will help individuals and teams to see their contribution within the context of the whole system and from the ‘customer’ perspective. Creating the conditions also involves advocating and influencing national policy to inform developments and build solid foundations and a supportive context for improvement.

“Have teams actively engaging with staff to bring about improvement using coaching approaches”.

Survey Stakeholder

5.2 Improvement Implementation Support

This involves facilitating improved outcomes and supporting teams in the redesign needed to address issues such as delayed discharge, promoting self-directed support, managing unscheduled care and optimizing post diagnostic support for people with dementia and their carers. This will be supported through national/large scale improvement programmes where appropriate. Also included is the deployment of tailored improvement support in response to proactive requests from NHS Boards and Integration Authorities to address local key priority issues and/or to work with services to support them in addressing key challenges including recommendations from inspection/scrutiny reports.
“Improvement science has its merits; it can be powerful and impactful.....but we need other approaches, which JIT does. I fear less evidence-influenced activity will be lost.”

Survey Stakeholder

a. Expertise in evidence, evaluation, intelligence and measurement for improvement
For practice to be evidenced-based individuals and teams need ready access to rapid reviews of evidence to inform improvement work. To enable teams to assess the effectiveness of interventions the IIR will also offer advice and guidance on the development of meaningful measures for improvement (both qualitative and quantitative). Not everyone assimilates data in the same way so support on the analysis, presentation and interpretation of data for improvement will be provided. Advice and support will be offered on how to pragmatically embed evaluation across improvement work including support for developing the business case for improvement. This function also includes offering an easily accessible repository of knowledge, tools and guidance

“Any improvement offer has to be seen in the context of the pressing financial conundrum i.e. huge financial pressure; so something costing more money is not credible. It’s how to get more or better for less. This needs to be strongly included in the principles.”

Survey Stakeholder

b. Capacity and Capability Building
Stakeholders have said that it is essential that local systems take ownership for improvement. Accordingly, the IIR will support NHS Boards and Integration Authorities to develop their quality improvement infrastructures. The IIR will do this by supporting implementation of change and improvement methods through coaching, facilitating, mentoring and consulting and by enabling easy and wide access to work with national and international experts on improvement. The IIR will also work with governance bodies to support them to provide effective leadership for improvement in quality and outcomes.

In addition the IR will work with partners to support the design and delivery of a range of resources to facilitate the development of knowledge, skills and competence in leading and ‘doing’ the improvement. This will include providing ‘faculty’ to support delivery of national and local training. Networks are essential to building enthusiasm and a force for improvement so the IIR will also facilitate knowledge exchange and common purpose through, for example, the Improvement Network for Integrated Care and Support.

“What is essential is organisations owning improvement. Only if they recognise the need to improve will they do it. The most important thing is that it begins and ends with the organisation recognising itself that it needs to improve.”

Survey Stakeholder

c. Innovation and Horizon scanning
This relates to combining knowledge of the local system with intelligence about the bigger picture to enable NHS Boards and Integration Authorities, and partners from other sectors where they interface with health and social care, to be proactive in their redesign and improvement work. The IIR will carry out ‘horizon scanning’ activities to identify promising practices across Scotland and internationally and by convening experts and frontline staff from across the system to provide ‘thought leadership’. It will also aim to be on the ‘front foot’ by considering the implications of imminent changes in the environment (e.g. social, technical) and what this might mean for NHS Boards and Integration Authorities.

“Innovation/horizon scanning – we often don’t have this leading edge capacity to look worldwide at local level .....if we want to stay ahead we need a person to look at international best practice.”

Survey Stakeholder
6. APPROACH AND METHODOLOGIES

Our starting point in facilitating and supporting improvement is not that current practice is always wrong or lacking. More often the drivers for improvement are that new evidence has emerged or that the context has changed making the current state no longer viable. Therefore the approach of the IIR needs to support NHS Boards and Integration Authorities to build on the strengths of the current situation whilst adapting and redesigning services in response to changing contexts.

Drawing on the experience of the three integrating bodies, a range of approaches, tools and techniques will be used and the choice will be informed by both the nature of the issue being addressed and the local context. The IIR will draw from a range of Quality Improvement Methodologies such as The Model for Improvement, Experience Based Co-design and Lean alongside wider change management methodologies including Appreciative Inquiry and Dialogic Practice. It was also recognized that the IIR will need the skills to support teams to work with the complexity that surrounds bringing health and social care together and that this will include supporting services to address behavioural, cultural and organisational changes necessary to make best use of collective resources. Facilitating knowledge exchange and dissemination by supporting networks and communities of practice is also a key aspect of the approach for IIR.

During this design phase, work was initiated to begin to consider an overall framework that identified the range of approaches/methods that the new integrated resource would draw from. There is an opportunity to develop a framework that builds on the approaches and tools of the three organisations and this work should be an early priority of the new integrated improvement resource.

“A huge impact could be made.....if the language across the country became shared and common. How can we understand what teams are to deliver if we don’t have a common language?”

Survey Stakeholder

It was recognised that any attempt to spell out the methods being used needs to be positioned within the context that the knowledge base about what works in supporting improvement is continually evolving and hence it is important that the IIR remains open to adopting new approaches which can improve the effectiveness of the support offered.

7. OUTSTANDING ISSUES TO BE RESOLVED THROUGH NEXT PHASE OF DEVELOPMENT

There are a number of outstanding issues to be addressed that need further discussion. These are noted below.

7.1 Co-production and Community Capacity Building

The Joint Improvement Team currently has responsibility for facilitating and supporting, in collaboration with other partners such as Co production network and Health and Social Care Alliance, community capacity building and co-production within HSCPs. Supporting co-production is essential to achieve the ambitions and outcomes of health and social care integration as well as public service reform more broadly. There needs to be a clear improvement support offer to Health and Social Care Partnerships to enable them to deliver on this fundamental aspect of Integration policy implementation.

“Must keep – activities around co-production and capacity building...there’s a strong network formed to support and keep building on good practice. It connects all and connects to all H&SCI bodies and parties.”

Survey Stakeholder
Further work is needed to clarify the interface between the co-production work located within the IIR and the wider public service approach which is led by the Scottish Government’s Directorate of Local Government and Communities.

7.2 The Interface between Performance Support and Improvement
Historically the Scottish Government has used improvement approaches when working with NHS Boards to address performance issues and part of Quality, Efficiency and Support Team’s role included deploying its improvement practitioners as part of performance support teams.

This interface between ‘improvement support’ and ‘performance support’ is complex as they are not completely distinct concepts. Further work is needed to understand what elements should rightly remain within Scottish Government and what should sit as part of an external improvement support function, and whether there are conditions under which joint working between Scottish Government and the IIR would be the best option. Over the rest of 2015/16 work will be undertaken to agree a framework that identifies the interface between improvement and performance support and how the interface is sensibly managed.

For example, the Scottish Government currently hosts the Unscheduled Care Performance Improvement Programme and the Acute Flow Programme. Once the work is complete on a framework for understanding improvement and performance support, the question of whether any elements of these programmes should sit within the new integrated improvement body will be revisited.

7.3 The Interface between Scrutiny and Improvement
A key issue that has consistently presented throughout the co-design process is a difference in views on what interface between scrutiny and improvement support is most conducive for driving overall improvements in health and wellbeing outcomes. Healthcare Improvement Scotland already hosts scrutiny and improvement support within one organisation, alongside a significant focus on producing evidence based guidelines. It had already initiated a piece of work to more clearly articulate its theory of how these functions of scrutiny, evidence and improvement support should interface to maximise the drive for improvement. In recognition of the decision to host the IIR within HIS, this work has now been extended to include colleagues from JIT, QuEST and the Care Inspectorate.

7.4 Children and Criminal Justice
There is a need to consider further the interface around improvement support for community health and social work children’s services, and criminal justice social work services given that a number of areas have located responsibility for these services with their Integrated Authorities. This is also relevant for the IIR role to support joint commissioning.

7.5 Joint Strategic Commissioning
The IIR will offer improvement support for Joint Strategic Commissioning. However, further work is needed to clarify the nature of this offer and ensure that this is commensurate with the resources available. This work will also consider the interface with the policy and performance support functions for Joint Strategic Commissioning that will remain in government.

8. CONCLUSION AND RECOMMENDATION
This paper represents the first stage in establishing an Integrated Improvement Resource. Proposals on structure, staffing, transition and risk management arrangements will follow once these founding proposals have been agreed.

The Joint Improvement Team Partnership Board and the Healthcare Improvement Scotland Board are asked to consider and endorse this paper before submission to the Health and Social Care Management Board for approval.
Giving the last word to our stakeholders, it is apparent that our challenge is to be pragmatic in all that we do and can be summed up thus:

“Less theory more practice; it’s not an industry! Go back to first principle; theories are not what people care about; its outcomes. Real life is messy; so cut to the chase; what are we here to do? What’s the best path and best use of resources?”

Survey Stakeholder
BIBLIOGRAPHY

6. Grint, K. Wicked Problems and Clumsy Solutions: The role of leadership, The British Association of Medical Managers, Stockport
POLICY CONTEXT

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

It requires the local integration of adult health and social care services, with statutory partners (NHS 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 aspects of adult hospital care that are most amenable to service redesign in support of prevention and better outcomes.

Nine National Health and Wellbeing Outcomes provide a strategic framework for the planning and delivery of Health and Social Care Services 7. The nine outcomes apply across all integrated health and social care services to ensure that NHS boards, local authorities and Integrated Joint Boards (IJU) are clear about their shared priorities, responsibilities and accountabilities for their delivery.

This suite of outcomes focuses on improving the experiences and quality of services for people using those services, carers and their families. In addition, people who work in health and social care services should be supported to feel engaged in the work they do and to continuously improve information, support, care and treatment they provide. Combined, the nine outcomes provide a strategic framework for the planning and delivery of health and social care services.

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http://www.gov.scot/Publications/2015/02/9966/downloads
STAKEHOLDER ENGAGEMENT AND CONSULTATION

The stakeholder engagement process comprised three formal components – facilitated interviews with stakeholders, two staff stakeholder events and an external stakeholder event. These activities are summarized below.

1. Facilitated interviews were carried out with 30 stakeholders between April and June 2015\(^8\). Stakeholders included:

- NHS boards
- Royal Colleges
- Integrated Joint Boards
- Local authorities
- Voluntary sector organisations
- COSLA
- Scottish Government, and
- Independent Sector.

The emerging themes from stakeholders in the health sector, the third, housing and independent sectors and local authorities, government and joint officers are provided below.

Seven emerging issues from the health sector

- the focus on improvement outcomes is key for the new resource
- improvement integration has to reflect the changing language and landscape in relation to the emerging health and social care partnerships
- heading into uncharted territory means we have to stop doing some things, as well as develop new things; it’s not just about one method or the other
- that culture, language and behaviour matters; and that starts at home, i.e. with the 3 integrating teams
- to embrace the scale of the change - not to slip into ‘old ways’ of political parochialism; language, behaviours
- there is a perception that HIS is top down, and
- the need to get on with something real and substantial as a result of bringing improvement resources together.

Seven emerging issues from the third and independent sectors

- that approaches to, methods and definitions of care and support reach beyond health and local authority support
- that improvement is as much about facilitating solutions as producing things
- what is the purpose/vision for the integrated resource, and its role in relation to regulation; scrutiny? The Care Inspectorate is a significant omission from this conversation
- governance - concern about the residing of the new organisation in a Health resource
- the role of strategic commissioning cited as key, with concern for its presence in the new organisation
- the recognition and development of ongoing improvement approaches that can be: e.g. localised; low budget; high impact; creative and collaborative, and
- that neither the JIT’s place at the table nor the impact of its work so far is compromised as a result of this integration.

\(^8\) Leishman K and McCready G, Improvement Integration: Views gathered from Stakeholders Final Report (Commissioned Work)
Seven emerging issues from local authorities, Government and Joint Officers

- that the new improvement resource primarily supports health and social care integration
- there are appropriate connections to partners in e.g. housing; early years
- there is clarity of the new resource in the improvement landscape
- that the one size approach to integration does not fit all
- good and existing practice is upheld and developed; co-production for example, asset-based working
- improvement starts with engagement and is not a prescribed approach, and
- the need for the new resource to proactively support partnership working itself, not as experts but as facilitators.

2. Staff stakeholder events were held on 11 May and 25 June 2015. Taking an ‘assets-based’ approach these events brought staff from the three organisations together to learn about each other’s approaches and successes. The output from these events has shaped the future of the new resource.

3. An external stakeholder engagement event was held on the 12th June 2015 at Heriot Watt University. This event was attended by 80 people who came to help co-design the IIR. There were high levels of involvement and energy throughout the day.

A key theme which emerged from interviews and the external stakeholder event is that tensions exist between different approaches to improvement and the need for the new integrated resource to adopt a mixed methodology deploying the approach/es most suited to the particular context and issues being addressed.

Building on this theme, the subsequent staff session focused on exploring some of these potential tensions such as the balance between large scale national improvement programmes and tailored support in response to individual requests from partnerships and NHS boards for bespoke support. They mapped the strengths and weaknesses of different approaches which highlighted that the strengths of one approach often mirror the weaknesses of another. This confirmed the benefits of using mixed methodology and the potential for the new organisation to truly be more than the sum of its parts.

In addition to the formal stakeholder engagement process, there have been numerous internal conversations and regular updates with the staff in the three organisations.
### Key Features of the Integrating Organisations

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<th>HIS Improvement Directorate</th>
<th>JIT</th>
<th>QuEST</th>
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<tbody>
<tr>
<td><strong>Scope</strong></td>
<td>Healthcare</td>
<td>Health and Social Care Partnerships</td>
<td>NHS organisations</td>
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<tr>
<td><strong>Role</strong></td>
<td>To support sustainable improvements in the quality of healthcare.</td>
<td>To support improved working across health, housing and social care boundaries to achieve better outcomes.</td>
<td>To support delivery of the NHSScotland Quality and Efficiency Framework particularly in high volume, high cost services</td>
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<tr>
<td><strong>Delivery Model</strong></td>
<td>• Employed and seconded experts in Quality Improvement and/or subject matter experts</td>
<td>• Responsive staffing model with small core team, ‘Associates’ and an Action Group with subject matter expertise.</td>
<td>• Employed and seconded experts in Quality Improvement and/or subject matter experts</td>
</tr>
<tr>
<td></td>
<td>• Emphasis on evidenced informed practice</td>
<td>• A partnership approach - governance and delivery</td>
<td>• Eclectic mix of improvement approaches</td>
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<td></td>
<td>• Clinical engagement and networks</td>
<td>• Working with a small number of Partnerships in an intensive way while engaging with all Partnerships to support integration and facilitate shared learning and development.</td>
<td>• Building large scale up from customised local testing</td>
</tr>
<tr>
<td></td>
<td>• Eclectic mix of improvement approaches</td>
<td>• ‘Bespoke’ programmes with local partnerships and locally owned with a ‘directed approach’ only where necessary.</td>
<td>• ‘Efficiency’ as a strand of quality</td>
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<td></td>
<td>• Testing small before large scale spread (PDSA*)</td>
<td>• Championing a personal outcomes approach and community capacity /co production Cross sector Improvement Network to facilitate knowledge exchange and build capabilities</td>
<td>• Prototyping improvement using case studies</td>
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<td></td>
<td>• Specialist expertise in use data of for service improvement</td>
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<td>• Specialist expertise in use of data for service improvement</td>
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<td></td>
<td>• Building capacity and capability for continuous improvement</td>
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<td>• Building capacity and capability for continuous improvement</td>
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*Plan, Do, Study, Act
CORE FUNCTIONS
Examples of what could be offered

1. ‘Creating the Conditions’ for improving outcomes
   - Work in partnership with NHS boards, local authorities, IJBs, H&SCPs and partners from other sectors to identify the key enablers and barriers to improvement with the ultimate aim of creating contexts which support sustained delivery of improved outcomes
   - Enhancing the capacity and capability of services and localities to deliver change
   - Providing a ‘boundary spanning’ function at national and local level to support service improvement in outcomes for care and support and enable staff within one part of the system to view their contribution within the context of the whole system, and
   - Advocating and influencing national policy to inform developments and build solid foundations and a supportive context for improvement

2. Improvement Implementation Support
   Facilitating national/large scale improvement programmes. Current examples are the safety programmes (Personal Outcomes Approach), Whole Systems Patient Flow and Focus on Dementia
   - Facilitating improved outcomes and the delivery of targets, indicators such as delayed discharge, Personal Outcomes, Self-Directed Support, unscheduled care and post diagnostic support for people with dementia and their carers, and
   - Deployment of tailored and responsive improvement in response support to proactive requests from NHS boards and health and social care partnerships to address local key priority issues and/or to work with services to support them in addressing key challenges including recommendations from inspection/scrutiny reports

4. Expertise in evidence, evaluation, intelligence and measurement for improvement
   - Rapid reviews of evidence to inform improvement work
   - Identifying ‘bright spots’, and capturing and sharing information on the ‘what and how’ the area has delivered improvement
   - Advice and support on how to pragmatically embed evaluation across improvement work including support for developing the business case for improvement
   - Advice and guidance on the development of meaningful measures for improvement alongside support on the analysis and interpretation of data for improvement, and
   - Offering an easily accessible repository of knowledge, tools and guidance

4. Capacity and capability building
   - Supporting NHS Boards and Integration Authorities to develop their quality improvement infrastructures
   - Supporting implementation of change and improvement methods through coaching, facilitating, mentoring and consulting
   - Working with partners to support the design and delivery of a range of resources to facilitate the development of knowledge, skills and competence in leading and doing the improvement. This will include providing ‘faculty’ to support delivery of national and local training
   - Facilitating knowledge exchange and common purpose through, for example, the Improvement Network for Integrated Care and Support

Working with governance bodies to support them to provide effective leadership for improvement in quality and outcomes
• Offering communications’ and engagement support in developing the web interface, mechanisms for capturing and sharing learning from the exemplars, and support for NHS Boards, Integration Authorities to raise the profile of their work through awards and publications
• Offering support to enhance the capacity and expertise by bringing in additional resources for improvement across health and social care in Scotland through applications to grant making bodies such as The Health Foundation and evaluation funding bodies
• Supporting a range of networks and communities of practice focused on improvement, and
• Enabling easy and wide access to work with national and international experts on improvement

5. Innovation and Horizon scanning
• Developing tools and guidance to support the work of improvement
• Supporting work to design and test innovative solutions to common challenges
• Horizon scanning to identify promising practices across Scotland and internationally, and
• Convening experts and frontline staff from across the system to provide ‘thought leadership’
APPENDIX 5

REPORT OF THE QUALITY IMPROVEMENT CONSOLIDATION GOVERNANCE ADVISORY GROUP

Background and Context

1. The Quality Improvement Consolidation Governance Advisory Group was established by Healthcare Improvement Scotland (HIS) with the following remit. To -

- Examine the current methods and approaches to governance of the three component bodies that will form the consolidated national approach to quality improvement support.
- Examine additional research and good practice that is identified as relevant to the governance of the national consolidation of quality improvement support.
- Develop appropriate governance proposals for the consolidation of national quality improvement support.
- Present recommendations to the Board of Healthcare Improvement Scotland.

2. A list of the individuals and organisations invited to take part in the Group is attached at Annex A.

3. The background to this work was the proposal by Scottish Ministers in November 2014 that the improvement function of three bodies, HIS, the Joint Improvement Team (JIT) and QuEST, which support health and social care efforts across the country, should be consolidated within HIS. The Group’s work has also taken into account the fact that those bodies are not the only ones involved in improving the quality of health and social care in Scotland. For instance, the Care Inspectorate has a statutory and key role in improving social care. It is necessary that the governance arrangements respect this and the part played by other stakeholders, whilst acknowledging the broader role that HIS has been asked to play in national quality improvement support.

4. It is intended that this new arrangement should be able to offer an integrated and coherent service of national improvement support, albeit the detailed scope of this work was still being discussed as the review was completed.

5. Following the Ministerial decision to proceed in March 2015, and in parallel with the work of the Governance Advisory Group, senior staff of HIS, JIT and QuEST began working to co-design the approach that the new consolidated improvement service will take and the functions it will offer. This work is likely to be completed in August 2015.

6. The task of this Governance Advisory Group has therefore been to devise a governance model that can provide oversight and strategic direction for this new service within the formal accountability framework of the HIS Board and with the flexibility to adapt to the final scope of the improvement function once it is agreed. As the wider governance structures within HIS may also be under review, the recommendations of this Group need to be able to adapt to those changes.

7. The Group has also been conscious that its recommendations must reflect the wider objectives of the integration of health and social care functions which are breaking new ground and challenging delivery bodies to work more closely together than ever before. No single body occupies the improvement space for health and social care. Rather the aim is to achieve the appropriate, timely and effective deployment of skills, experience and expertise from a range of partners, including Healthcare Improvement Scotland, in supporting the implementation of improvement in health and social care. It is therefore crucial that
the governance model adopted for the improvement function makes a contribution to this effort by recognising the shared responsibility of central government, local government, the third sector and the independent sector for its success.

8. In legal terms, bringing the functions together under the auspices of HIS means that the Board of HIS will be ultimately accountable to Ministers for the strategy, performance management and allocation of resources to the national improvement service. The governance entity being developed by this Group will, in turn, have a clear legal accountability to the HIS Board, but the Group readily acknowledged that the successful governance model also needs to reflect a more complex environment of political accountability and stakeholder accountability in order to engender a strong partnership ethos and a shared sense of accountability.

9. Furthermore, close strategic working with partners who have their own responsibilities for improvement such as the Care Inspectorate (Social Care and Social Work Improvement Scotland), the Improvement Service and others will be a crucial aspect of the new consolidated improvement function.

Work of the Governance Advisory Group

10. The Group met on 3 occasions in May and June 2015 and discussed the following issues –
   a. Scottish Government briefing on the background to the consolidation process
   b. The current governance arrangements of HIS, JIT and QuEST and potential scope of the new consolidated improvement function
   c. Key characteristics of the new governance arrangements, highlighting in particular, the strengths of the current system which should not be lost. A list of those key attributes is attached at Annex B
   d. A review of a range of governance models which could offer ideas for the new governance arrangements. These included
      i. the Scottish Health Council, ii. HIS Quality Committee,
      iii. a Scottish Funding Council committee of stakeholders,
      iv. the Housing Support Enabling Committee which is a collaboration between the Coalition of Care and Support Providers in Scotland and the Scottish Federation of Housing Associations
      v. the Integrated Joint Board model
   e. The preferred status, accountability structure and membership of the new governing entity. Views expressed on this are listed in Annex C.

11. During the meetings, members of the Group agreed that they wished to develop a new governance model for the consolidated improvement function which would harness the best of the previous arrangements. In particular it should –

   a) Demonstrate through effective leadership and governance a positive impact on the health and well-being of the population
   b) Ensure a breadth of participants so that the new governing entity has knowledge of and can offer value along the whole health and care pathway, balancing people with ability and diversity of perspective
   c) Provide a role model of collective leadership and ownership not just collaboration that helps to achieve the end game of integrated care
   d) Achieve and sustain legitimacy in the eyes of its partners, maintaining the trust of and having influence with the full range of stakeholders and partners.
12. It was recognised that the existing governance models all had strengths and weaknesses and the aim must be to devise a new model which balances –

- **Influence & Independence** – experience over the years has shown that a price of too much independence can be a lack of influence with funders and decision makers. On the other hand a governing body which is seen solely as the ‘servant’ of a single master can find its relationship with other potential partners damaged.

- **Impact & Partnership** – once again, this is a matter of balance. Some governing bodies that have placed too much emphasis on voluntary partnership and collaboration have ended up achieving the lowest common denominator in order to keep everyone on-side because members are not willing to make hard or unpopular choices. At the other extreme, governing bodies which pay little attention to stakeholder partnerships can find themselves isolated and their effectiveness limited.

The Group was unanimous in agreeing that the recommended governance model should harness the best of the existing models and create a new governance structure which provides effective leadership, resulting in a real positive measureable impact on the health and wellbeing of the people of Scotland. **Recommended Governance Structure**

**Accountability and Collaborative Framework**

13. The Group recommends that a governing entity, with the working title of the *Scottish Improvement Partnership for Health and Social Care (SIPHC)*, is established as a formal committee of, and with legal accountability to, the HIS Board.

14. In addition, it is recommended that mechanisms are adopted which ensure a softer but nonetheless crucial level of political and stakeholder accountability to a wider group in order to maintain the trust, support and partnership of key stakeholders. It is recommended that this reflects the successful experiences of the JIT Partnership Board in working with a range of partners and of the HIS Board in its delegated oversight of the Scottish Health Council while meeting the needs of the future. The Public Services Reform (Scotland) Act 2010 already puts an obligation on HIS to exercise ‘a duty of cooperation’ between itself and other bodies, including the Care Inspectorate.

15. It is recommended that –

a) The HIS Board reviews its level of engagement with COSLA/ local government to explore how it might establish a mutually satisfactory form of dialogue which complements its existing engagement with the health sector and existing arrangements in the local authority sector. Its aim should be to achieve reciprocal and appropriate, high level/political accountability for the successful delivery of the consolidated improvement function without compromising its formal accountability to Scottish Ministers;

b) The new Partnership develops, on behalf of HIS, a Memorandum of Understanding with its sectoral partners –local government, NHS, the independent sector, the third sector, and the Care Inspectorate which covers matters such as

   i. Agreed common purpose of working together

   ii. Commitment by the Partnership to consult on its forward plan, and annual business plans

   iii. Agreed annual process for reporting to the sectoral partners on the work, progress and performance of the Partnership, including annual meetings with the Chair of the Partnership;

a) The MoU should recognise the vital importance of close governance engagement with the strategic delivery bodies that support improvement efforts in this sector, in particular the Improvement Service and other bodies such as NHS Education Scotland
and the Scottish Social Services Council;
b) The MoU should also set out how the Partnership will consult with and report its progress to its other stakeholders, including the Integrated Joint Boards set up across the country.

**Purpose and Remit**

1. It is recommended that the purpose of the Partnership is to –

   - Support Healthcare Improvement Scotland in fulfilling its duties with regard to the quality improvement support it provides for health and social care in Scotland
   - Support and ensure effective partnership working between Healthcare Improvement Scotland, local government, the NHS in Scotland, Scottish Government, the third and independent sectors, the housing sector and its strategic delivery partners such as the Care Inspectorate and the Improvement Service in order to ensure good quality improvement support.

2. It is recommended that the duties of the Partnership are

   - To recommend for approval to the HIS Board the forward plan, priorities and business objectives of the HIS improvement function, within the wider policy framework and funding set by the Board and following consultation with the HIS Board, local government, NHS, the third and independent sectors and IJBs
   - To deliver governance oversight of the performance of the HIS improvement function and to be accountable for this to the HIS Board
   - To build effective relationships with local government, health boards, the independent sector and the third sector as well as other partners
   - To report annually on the performance of the Partnership, meeting annually with representatives of local government, health boards, the independent and third sectors
   - To make reports to the HIS Board as required
   - To ensure the Partnership operates to high standards of corporate governance consistent with the Nine Principles of Public Life in Scotland
   - To work with other parts of the HIS governance structure, in particular those overseeing the scrutiny and evidence functions, to ensure a coordinated and integrated approach to the governance of the improvement service
   - The Partnership Chair to be responsible for raising with the HIS Board Chair and Chief Executive any issues of concern that the Partnership may have relating to the operation and effectiveness of the improvement function

**Membership**

16. It is recommended that

   - a) The Chair of the Partnership should be appointed by Scottish Ministers and be a member of the HIS Board. That individual should have a background and skills which allow them to maintain the trust of all stakeholders.
   - b) In addition to the Chair, the Partnership should have up to 11 members appointed for a maximum of 4 years (with an option of one term extension) –
     - i. 2 members of the HIS Board appointed by it on the recommendation of the HIS Chair
     - ii. 2 members of the public who have user or carer experience of the health and social care services provided by IJBs to be recruited by the Partnership using the Scottish Health Council’s public partner process but with relevant skills and experience. These individuals to be appointed by the HIS Board on the recommendation of the QIP Chair.
     - iii. Up to 7 members appointed to reflect the following range of skills and knowledge
       - Knowledge of the frontline delivery of health and social care services
including those provided by the independent, voluntary and housing sectors as well as by the Integrated Joint Boards

- Knowledge of the strategic national agendas within which the improvement service will require to operate
- Knowledge of health and social care improvement good practice techniques and methodologies
- Ability to operate strategically, taking collective responsibility for the direction and performance of the improvement service.

v. The 7 members referred to above to be appointed by the HIS Board on the recommendation of the Partnership Chair. A transparent but light touch recruitment process to be overseen by a 3 person panel established by the SIPHC Chair (possibly consisting of the Chair of the Partnership, a member of the HIS Board and a representative of COSLA/local government). UBs, local government, Health boards and the representative bodies of the independent, third and housing sectors to be invited to nominate individuals for consideration who have the required knowledge and skills.

vi. In order to aid the transition to the new arrangements, members of the current Joint Improvement Partnership Board should fill at least 3 of the above places for the first two years; at least one member should also have experience of the work of QuEST.

c) The senior member of HIS staff with responsibility for the consolidated improvement function should attend all meetings; other HIS staff may attend with the agreement of, and at the request of, the Partnership Chair.

d) The Chair of the HIS Board cannot be a member of the Partnership but has the right to attend its meetings.

Transition Period

17. It is recommended that the Partnership meets initially every two months and then agrees in due course the appropriate frequency of its meetings going forward. A shadow Partnership should be established in autumn 2015 with one of its early tasks being to oversee a clear transition plan to the new arrangements. Thereafter the Group noted that there may need to be wider changes to the governance structure within HIS and that the public service landscape may continue to evolve; the Partnership will need to adapt as those changes take effect and as it itself develops over time.

Other Recommendation

1. During its deliberations, the Advisory Group noted that the consolidation of the improvement service is only one part of the larger national effort to integrate the provision of health and social care services and to break down the old barriers between the different sectors. It also noted that while there will be new governance arrangements for the consolidated function, ultimate accountability will lie with Healthcare Improvement Scotland - the name of which sits oddly with oversight of an integrated health and social care service. The Advisory Group would like to suggest therefore to the Board of Healthcare Improvement Scotland that it give consideration to adjusting its informal ‘trading name’ at some point to better emphasise the integrated nature of the responsibilities it will soon have.

7th August 2015
## ANNEX A

### MEMBERS OF THE QUALITY IMPROVEMENT CONSOLIDATION GOVERNANCE ADVISORY GROUP

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Colin Mackenzie</td>
<td>Independent Chair</td>
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<tr>
<td>Jan Polley</td>
<td>Facilitator</td>
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<tr>
<td>Jim McGoldrick</td>
<td>Chair, Joint Improvement Partnership Board</td>
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<tr>
<td>Lucy McTernan</td>
<td>SCVO</td>
</tr>
<tr>
<td>Rami Okasha</td>
<td>Head of Quality and Improvement, Care Inspectorate</td>
</tr>
<tr>
<td>Karen Anderson</td>
<td>Director of Strategic Development/Deputy CE, Care Inspectorate</td>
</tr>
<tr>
<td>Gerry Power</td>
<td>Deputy Director, JIT</td>
</tr>
<tr>
<td>Mary Taylor</td>
<td>Chief Executive, Scottish Federation of Housing Associations</td>
</tr>
<tr>
<td>Ron Culley</td>
<td>Chief Officer, Health and Social Care, COSLA</td>
</tr>
<tr>
<td>Linda Semple</td>
<td>Head of QuEST, Scottish Government</td>
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<tr>
<td>Mairi Macpherson</td>
<td>Head of Person-Centred and Quality Team, Scottish Government</td>
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<tr>
<td>Jane Mackenzie</td>
<td>Deputy for Chief Social Work Adviser, Scottish Government</td>
</tr>
<tr>
<td>Kenneth Hogg</td>
<td>Director, Local Government and Communities, Scottish Government</td>
</tr>
<tr>
<td>Alan Baird</td>
<td>Chief Social Work Adviser, Scottish Government</td>
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<tr>
<td>John Burns</td>
<td>CE, NHS Ayrshire and Arran</td>
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<tr>
<td>Margaret Whoriskey</td>
<td>Director, JIT</td>
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<tr>
<td>Cathie Cowan</td>
<td>Chief Executive, NHS Orkney</td>
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<tr>
<td>Annie Gunner Logan</td>
<td>Director, Coalition of Care Providers Scotland</td>
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<tr>
<td>Angela Leitch</td>
<td>Chief Executive, East Lothian Council</td>
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<tr>
<td>Fiona Lees</td>
<td>Chief Executive, East Ayrshire</td>
</tr>
<tr>
<td>Sara Gadsden</td>
<td>Head of Change and Development, Improvement Service</td>
</tr>
<tr>
<td>Geoff Huggins</td>
<td>Acting Director for Health and Social Care Integration</td>
</tr>
<tr>
<td>Ian Welsh</td>
<td>CE, Health and Social Care Alliance</td>
</tr>
<tr>
<td>Brian Montgomery</td>
<td>Interim Chief Executive, NHS Fife</td>
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<tr>
<td>Keith Redpath</td>
<td>Chair of Chief Officers Group</td>
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<tr>
<td>Brian Moore</td>
<td>Director/ Chief Officer for Inverclyde HSCP</td>
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<tr>
<td>Ranald Mair</td>
<td>Chief Executive, Scottish Care</td>
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<tr>
<td>John Glennie</td>
<td>Non Executive Director, HIS</td>
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<tr>
<td>Susan Siegel</td>
<td>HIS Public Partner</td>
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<tr>
<td>Robbie Pearson</td>
<td>Deputy Chief Executive/Director of Scrutiny and Assurance</td>
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<tr>
<td>George Black</td>
<td>Non Executive Director, HIS</td>
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<tr>
<td>Brian Robson</td>
<td>Executive Clinical Director, HIS</td>
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<tr>
<td>Hamish Wilson</td>
<td>Vice Chair of HI</td>
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<tr>
<td>Ruth Glassborow</td>
<td>Director of Safety and Improvement, HIS</td>
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KEY CHARACTERISTICS OF THE NEW GOVERNANCE ARRANGEMENTS

1. Agreed in discussion that good governance means
   - Mechanism by which an organisation or service is directed and controlled
   - Leadership and stewardship
   - Oversight of staff and other resources including finance
   - Clarity of direction
   - Transparent decision making
   - Responsiveness to stakeholders
   - Ability to build trust and credibility with and influence stakeholders/those being represented
   - Accountability – holding to account and being held to account, and
   - Management of risk.

2. What is valued as a strength in current JIT governance
   - Range and reach of constituent representatives means it can
     o offer value along the whole health and care pathway
     o access a wide range of tools to address problems
   - It’s perceived independence can be helpful in reaching some areas
   - It’s governing body has been on a journey from being a group of representatives to a Board that collectively governs integrated activity
   - It’s work makes use of and is guided by evidence (in all its forms)
   - It is comfortable with a diversity of solutions without the need to oblige compliance
   - It acts as a role model of partnership in operation, and
   - Experience of being flexible

3. What is valued as a strength in current HIS governance
   - Working closely with local and national NHS staff means its work can have a deep reach
   - Built experience of working in partnership with NHS partners and Care Inspectorate
   - Increasing focus on person centred governance e.g. Public Partners and wider care partnerships
   - There is clarity of resources and resource management
   - Experience of operating diverse governance relationships e.g. Scottish Health Council, Scottish Medicines Consortium and wider diversity of board members
   - There is clarity of relationship with Scottish Government increasingly based on agreed outcomes rather than detailed oversight
   - Governing body has on a journey towards greater confidence in its independent role, and
   - Experience of being flexible.

4. What benefits the group would like to see resulting from the new governance model
   - Inclusion of third, independent and housing sector, balancing people with ability and diversity of perspective
   - Greater evidence of impact of work
   - Demonstrate positive impact of work on health and well-being of our population
   - Our governance encourages and helps achieve the end game of integrated care and is not viewed as a barrier to it
   - Greater influence/ connectedness/ support for work (balanced with independence)
   - Achieve legitimacy in eyes of partners
• Norm becomes improvement from end to end of the pathway with people looking across all sources of expertise including co-production, and
• Achieve collective leadership and ownership and not just collaboration.
1. Group discussions suggested that the **status and accountability structure** for the new governing body should reflect the following
   - The Scottish Health Council (SHC) model is a helpful illustration of how a governing body can be hosted within HIS without being wholly assimilated within it
   - The Integrated Joint Board governing model is a useful example of how a body can work with differing types of accountability
   - The new body must be designed to avoid a single accountability route
   - Perhaps the body could have accountability to the Improvement Service board too; this would underline the links between improvement across the sectors
   - Helpful for the new body to have its own logo to delineate the improvement offering
   - Could HIS consider a name change to signal the broadening of its remit rather than just healthcare? HIS is not a health board
   - The SHC/Scottish Medicines Consortium model has considerable perception benefits – maybe name of the new body to include ‘partnership’ or ‘consortium’
   - May be helpful anyhow for HIS to delineate between its 3 roles in the short to medium term
   - The Chair of this new body should sit on/ have a link to the HIS Board
   - Should the new body be accountable to the Health and Social Care Partnerships as its main customer for improvement support? It is the Integrated Joint Boards that are accountable for achieving improvement
   - Thought needs to be given to the new body’s links to the Care Inspectorate and Improvement Service; MoU or common members?
   - The new body should be at arms length from the HIS Board with clarity of its autonomy, building on the partnership principles of accountability developed by JIT, and
   - The respective roles of the HIS Board and the new body need to be clear.

2. Group discussions suggested that the **membership** of the new body should reflect the following
   - Membership should reflect the range of interests but individuals should not represent those interests
   - The new body’s members should be ready to work as a corporate body with all members being equal
   - Membership should reflect the breadth of interests in the health and social care merger intentions
   - Members should not be the sole source of accountability
   - Membership of the governing body should reflect stakeholder interests, knowledge of the front line and those with delivery experience rather than the ‘usual suspects’ from representative bodies
   - Members must also have ability to be strategic and have the wider knowledge to know what is coming over the horizon
   - Members should also reflect the importance of prevention and have community knowledge
   - Need to guard against the body being too big; we can fill any gaps in other ways, and
   - We should tap into the public partners model which already exists in HIS