Integrating Care in Scotland

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Abstract

This issue of *Healthcare Quarterly* includes the second of a three-part series developed by Ontario's The Change Foundation featuring international perspectives on health service delivery models that improve system integration and ensure seamless services and better coordination. Part 1 featured Chris Ham, chief executive of the London-based King's Fund think tank. In this issue, Geoff Huggins, director for Health and Social Care Integration in Scotland, discusses Scotland's experience and lessons learned after legislating integrated health and social care in 2015.

> We want to ensure that adult health and social care services are firmly integrated around the needs of individuals, their carers and other family members; that the providers of those services are held to account jointly and effectively for improved delivery; that services are underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve rather than the needs of the organizations through which they are delivered and that those arrangements are characterized by strong and consistent clinical and professional leadership.
>
> Nicola Sturgeon, Member of the Scottish Parliament, Deputy First Minister and Cabinet Secretary for Health and Wellbeing, December 2011

Ontario's current moves toward integrating healthcare reflect an understanding that the well-being of its citizens is determined by a dynamic mix of circumstances, including family history, employment, income and personal relationships. Yet the services the province offers to support those lives – notably its systems for social welfare and healthcare – are rigidly designed and operate separately, even when providing help to patients and caregivers who need services from both. Scotland, once in the same situation, is changing that with a bold plan for integrating health and social care that has lessons for Ontario and Canada as we look to align how we provide care with how people live.

To share some of those lessons, Geoff Huggins (director for Health and Social Care Integration in Scotland) was invited to speak at The Change Foundation's Toronto office in late 2017. Huggins was the second health leader from the UK to speak at a series of meetings on integrating care organized by The Change Foundation with partners from the University of Toronto: the Institute of Health Policy, Management and Evaluation, the Health System Performance Research Network and the Dalla Lana School of Public Health.

For generations, Scottish life expectancy was comparable to that of its neighbours, but it has been losing ground since the 1960s, a trend researchers have attributed to growing socioeconomic disparity (Dodds 2014). A 2014 report from the Scottish government said the country has "long standing problems of health and well-being," ranking last for life expectancy among 16 Western European countries (Burns 2017).

In the face of clear indications of worsening health, and after many years of focusing care on complex chronic conditions and multimorbidity, Scotland officially launched integrated health and social care, with legislation that came into effect in April 2016. The law created 31 "Integration Authorities," further subdivided into 101 "localities." The structure puts heavy emphasis on local action for local needs (Scottish Government 2018).

Scotland Moves to Integrated Health and Social Care

Huggins told the audience at The Change Foundation in Toronto that the move to integration was driven by the need to rethink a healthcare system that was an "unsustainable, unaffordable model of care, delivering an unsatisfactory quality of care."

Complicating Scotland's challenges are deep variations in healthcare delivery across the country. To illustrate that, Huggins used a slide showing nearly 300% variation across Scotland in the rate of hospitalization among people >65 years of age. It showed that seniors in Glasgow City had a one in 80 chance of being in hospital on any given day, whereas seniors in Aberdeenshire had a one in 200 likelihood. The gap is not unique; there are similar differences in other areas, including emergency care.

In the past, Scotland would have taken a highly centralized approach to the issue of reforming healthcare, publishing guidelines, budgets and targets it expected all providers to follow. Now, Huggins said, they realize a centralized approach will not work for several reasons. With so much variation, central planning is unlikely to hit on a combination of tools that will work for 31 different Integration Authorities. Centralized approaches also put more emphasis on whether a plan was delivered than on whether it increased sustainability and improved health.

Moreover, easily measured factors, such as wait times or delayed discharge from hospital, are "a very thin way of understanding healthcare … in that the best healthcare in those terms is the one you move through fastest," Huggins said. Quality of care, however, is not captured.

Consequently, the Scottish government's new approach to its healthcare problems does not attempt to make hospitals and other providers more efficient while operating as they always have. Rather, its aim is to move more care into the community and use hospitals less – by managing chronic care in the community, by considering whether elective procedures are valuable, by introducing better pathways to specialist care and by improving health overall (which is why links to social care are so important).

> The "integrated space" contains all National Health Service (NHS) care, both in the community and in hospital as well as all health-related social care – care at home, residential care, some housing support and some aids and adaptation assistance.
>
> Geoff Huggins

Features of Scotland's Integrated Approach to Health and Social Services

What will be different for individuals:

- people will be equal partners with their clinicians, working with them to make decisions about their care;
- health and social care professionals will work together to help older people and to ensure that those with more complex needs receive the support they require and, where possible, to live well and independently;
- hospitals will focus on the medical support that acute care can and should provide, and stays in hospital will be shorter;
- everyone will have online access to a summary of their electronic patient record, and digital technology will transform delivery of services across health and social care;
- mental health will be considered as important as physical health; and
- people will receive more sensitive end-of-life support, where possible, in the setting they choose.

What will be different for communities:

- most care will be provided locally through an expanded community health service, avoiding the need to go to hospital;
- practices will consist of complementary teams of professionals, bringing together clusters of health support and expertise;
- access will be quicker to continuity of care from a team including GPs, highly trained nurses, physical therapists, pharmacists, mental health workers and social workers;
- local practices will provide more information and offer better advice so that people will not need to go to hospital for specialist care; and
- families will receive more integrated and extended primary and community care for their children, including more home visits. Teen mothers will get more intense support.

What will be different regionally:

- some specialist clinical services will be delivered regionally for quicker access and better results and
- specialized centres will handle the growing demand for planned surgery, particularly from an aging population. This will reduce pressure on other hospitals.

Unleashing Creativity

How care is reshaped in each of the Integration Authorities is left up to the people who work there. They are coming up with some innovative changes. Glasgow, for example, where the rate of hospitalization for seniors was so high, stopped

assessing people's need for long-term care while they were still in hospital. Instead, patients were moved to residential-style step-down facilities for a short time, where their need for continuing care was assessed. The result was that 70% more people went back home, instead of to an institution, whereas delayed transfers – the term for people stuck in hospital waiting for a long-term care bed – decreased by 60%.

There is some resistance, Huggins admitted, after 70 years of standardized NHS service, to the idea that some of the care your friend gets in the next Integration Authority over is not available to you. But trying to deliver identical care to every corner of Scotland would be misdirected energy, Huggins said.

"If we tried to standardize this, that would be all we did and we would have done maybe one component of the system," he said. "This expectation that anything that's available to somebody in one area of Scotland should be available to everybody everywhere, I think if we did that you would see the bar come down pretty quickly on what was available at all."

The Changing Role of the Government

The new approach to healthcare has substantially changed the role of the government, which must navigate the difficult course to surrendering power to bodies closer to the front line. Politicians like to be seen stepping up with solutions when problems arise, but doing that does not achieve the "fine-grained decision making" that will lead to better, more sustainable care.

Integrated care, Huggins said, needs a different approach, where the government gives high-level direction on outcomes, standards and quality and then backs off to allow local responses to translate those requirements into practice. Dictating solutions and monitoring results smother innovative instincts in front-line staff. "We have great people," he said. "We need to treat them as great people."

The same challenge is to be found in the English NHS, as Helen Bevan, another speaker in the series, made clear in her talk. The tradition of top-down change and heavy-handed approval systems – "the permission culture" – gets in the way of improvement, she said.

What Did Not Work

At one point during The Change Foundation meeting, Huggins recommended talking with other health leaders and organizations doing similar work. That is not, he said, because transplanting ideas wholesale from one place to another works (a point another speaker in the series, Chris Ham, also made when he said you can't drag and drop an idea from one place to another). Rather, Huggins said that it is essential to consult people who will tell the truth and give both sides of the story, not glossing over challenges, because history is written by winners and can seem deceptively easy. Here are some things that Huggins told the audience will not work, and some of the mistakes he described.

The desire to improve healthcare means constant pressure to find effective innovations and exploit them as broadly as possible. But the beloved concept of scaling and spreading every good idea that comes along is not doing well in Scotland's integration efforts.

"It's a wonderful government model – we'll find the answer and we'll tell people the answer and they will do the answer and it will be great," Huggins said. However, so far there's little evidence that anyone has found ideas certain to fix problems across the board, so rather than focusing on scaling and spreading individual innovations, Huggins would rather see people sharing information, ideas and evidence. "Find out what everybody else is doing, so you know how people are approaching the same problem you're trying to fix, you know what the evidence base says and you find the best solution for your area, whether that's something somebody else has done or something you do yourself. Then you track it against outcomes and you evaluate it appropriately."

As mentioned, Huggins has little time for standardization. None of what Scotland is attempting is about reshaping activity to approved patterns; rather, it is to produce better outcomes. Measuring that, in the absence of standardization, is more difficult, but better than the old tendency to focus on certain outcomes precisely because they are easy to measure.

Quality and efficiency do depend on measurement, and Scotland has not rejected that concept. But it has been reconfigured. Each Integration Authority has been asked to measure outcomes: accident and emergency performance, emergency attendance, admissions, unscheduled care bed days, delayed discharge, end-of-life care and balance of spend. However, there are no national improvement goals for them. Instead, Integration Authorities were asked to state, against their baseline, where they expected to get to.

The more important shift, however, was telling authorities not to look at the results in isolation. Rather, they were to look for links among them and use them to gain an understanding of their system. Admissions from emergency, for example, and unscheduled bed days may suggest shortcomings in preventive care; measuring waits in emergency should take delayed discharge into consideration because it might have been impossible to admit patients.

Huggins's talk was given just before Scotland's former chief medical officer Sir Harry Burns released a report on targets and indicators that will map out a broader way of understanding quality in integrated health and social care. Burns reviewed all the measures and targets that Scottish healthcare uses and made recommendations on them. He suggested, for example, that tracking the number of patients who get treatment in

accidents and emergencies from each general practitioner would give insight into needs for other services, such as holistic approaches to social support or mental health support in association with primary care (Burns 2017).

Despite the emphasis on local approaches in almost every aspect of Scotland's healthcare reform, there are >50 organizations producing and creating data with different records, which Huggins called "a complete menace." Since digital health was added to his responsibilities in June 2017, he has been working hard to centralize health information into a single platform that will support the health reforms they are working to put in place.

Another flaw he identified in their process was underinvestment in organizational development, by underestimating the amount of change they were putting people through and the degree to which they should have worked with people's behaviour and belief systems as they introduced reforms.

Huggins described flaws in introducing change to the public as well. Some authorities, he said, got bogged down in explaining changes, instead of engaging the public as partners. Others simply have been preoccupied with getting the new systems up and running, and building relationships with patients and carers was not given priority. Both approaches built community resistance to the changes.

One continuing issue is the overlap between old and new approaches to healthcare. For now, hospitals are still being tracked for performance on goals and targets, whereas other parts of the healthcare bureaucracy are telling them to be collaborative, to consider the upstream and downstream implications of what patients need and how they are responding. "That takes you into visceral, day-to-day conflicting narratives about where the future is going," Huggins said, adding, however, that at least the problem is recognized and talked about openly.

What Is Working

For all the struggles between theory and practice and old and new approaches, Huggins told the meeting that integration is working best on the front line, where patients and providers meet. "At the point at which you give groups of people the opportunity to work together and differently, they will generally find good and sensible things to do, and our challenge in that space is to be out of the way and not try to overly manage it." The important thing, he said, is not to have too many systems and processes in place that will get in the way of creative innovation.

Despite the problems presented by collecting health information in too many places, Huggins reported significant success in how data are used to support change. All the Integration Authorities use data very effectively to understand what is going on in their area, he said, and to plan for it, even though they are relatively new at doing so.

In the absence of the traditional "solution" to healthcare's problems – pouring in more money – it is important to demonstrate success. Huggins advised taking time to figure out what matters to your audience – whether it is access or quality or a better work experience – and then showing how integration is making things better. In that, he was echoing our first speaker, Chris Ham, CEO of the King's Fund, who referred to management expert John Kotter when he told people at his talk, "Demonstrating success helps you generate more success. It builds the competence and the belief that something can be done, something can be achieved."

Huggins said it also helps that most healthcare workers will favour reform if they believe it will mean other people do their jobs in ways that will make their own easier. Physicians are no exception to that rule, he said, and he suggested that one of integration's successes has been to give GPs clinical leadership in the localities, responsible for their own functions and essential in local partnerships. The primary care teams they work with are seen as a way to spare GPs some work others can handle, while offering them better support from both social services and specialists.

Despite financial pressures, money is sometimes the solution to the problem. Scotland's plan to move care into the community was being thwarted by a strong job market; community caregivers did not stay in their jobs because they could do better elsewhere. The solution? To pay all homecare workers a living wage – effectively about a 20% increase over two years. The money was redirected from the NHS budget.

The Journey Continues

The decision to integrate health and social services was a big change for Scotland, driven by concern for the poor health of its people and the unsustainability of its healthcare system. But it was not, of course, the first attempt to improve care, as Huggins pointed out. Collaborative care, community partnerships and reshaping care for older people had all been considered and tried in different ways, and consulting with experts and other jurisdictions will continue.

> I presume this is a journey, rather than a destination, where you think about what things you might want to do next, rather than where we want to land.

This is a model to emulate in Ontario and continue to watch as we move forward toward a better integrated system that better cares for its citizens – patients and caregivers alike. HQ

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