Glasgow Caledonian University

University for the Common Good

commonhealth CATALYST

Health and Social Care Integration in Lanarkshire: Qualitative Research Findings

Kirsty Strokosch (University Of Strathclyde)

October 2023

UKRI Arts and Humanities Research Council

The Hamilton Mausoleum,
Hamilton, South Lanarkshire

Summary of Findings

Introduction

This report presents insights and learning under the second theme of the CommonHealth Catalyst project, 'Mapping the Health and Wellbeing Ecosystem'. It presents the preliminary analysis and findings from qualitative research exploring Health and Social Care integration in Lanarkshire.

This exploratory study was conducted between February and May 2023, with 26 interviews and two focus groups conducted with respondents from Health, Social Care, the third sector and people with lived experience. The research considered the following questions: what does integration mean; to what extent is integration taking place in practice; and what impact is integration having on reducing health inequalities? This report presents the main findings from the preliminary analysis.

Understanding of integration

While a few respondents said that integration concerns relationships at a strategic decision-making level and the establishment of new governance structures including Integrated Joint Boards, in line with the Public Bodies (Joint Working) (Scotland) Act 2014, most defined integration more broadly. They said it was about day-to-day working together by multiple actors, across organisational and sectoral boundaries to share knowledge and skills, and to reduce duplication during service delivery.

Integration in practice

Multi-disciplinary teams (MDTs)

At the service delivery level, integration has taken shape through MDTs, with Health and Social Care professionals working together to assess and provide care to patients/service users. Those MDTs work in different ways across Lanarkshire, which was described as causing confusion for organisations making referrals. In North Lanarkshire (NL) Health and Social Care staff were co-located, in South Lanarkshire (SL) they sat separately but had regular joint meetings and worked jointly on short-term projects.

The effectiveness of MDTs was linked to team leadership, achieving buy-in from staff for job change and understanding each other's roles to establish and maintain relationships and reduce duplication. However, unyielding structural constraints were uncovered (i.e. separate budgets, IT systems, governance structures and entrenched cultures) which made working together more challenging. Importantly, a disconnect was also identified between senior management and staff, who do not feel listened to despite being well placed to understand needs and the effectiveness of service processes.

Role of the third sector

The third sector was understood as providing essential support services around prevention and early intervention, therefore, playing a central role in Health and Social Care. However, that role was not described as integrated within the Health and Social Care system. For example, the sector is referred onto rather than working in partnership with MDTs during service delivery and MDT staff often did not know which local services were available within the complex local third sector landscape. The analysis also demonstrates a lack of engagement with the third sector local strategic decision-making, with respondents noting the ineffectiveness of current engagement structures. This was described as leading to a disconnect between decisions made and the effectiveness in meeting local need. To support the aims of early intervention, prevention and contend with increasing demand, long-term investment from government in the third sector was frequently called for.

Impact of integration

Integration in its current form was regarded as having impacted ways of working (both positively and negatively) through the establishment of MDTs. Furthermore, the strategic direction around integration has, to some extent, emphasised the role of the third sector, particularly in NL, where more funding had been directed into the sector. However, integration's impact on people using services or on reducing inequalities was not clearly evident through the analysis. Health and Social Care services are designed to deliver for the population, rather than the most vulnerable, and measures are not in place to uncover and contend with inequalities at the service level. Furthermore, integration does not, and most likely cannot, contend with the root causes and complexities of inequality, which require input and action from various actors within the system, with central government needed to steer these actors towards common goals. This is linked to the current metrics used to measure impact, which focus predominantly on the numbers of people accessing/leaving services or being treated, rather than qualitative indicators which measure outcomes on population health, need or experience.

A way forward? A whole-system and locality-based approach

The analysis suggests the need to zoom out to understand the wider system of actors and relationships, the macro-level enablers and constraints impacting health, wellbeing and inequality, and the pressures and capacity within different parts of the system. Nevertheless, at the same time, it suggests strengthening a locality-based approach by zooming in to focus on the needs, resources and connections within local communities and to co-ordinate and capitalise on these to contend with increasingly complex demand.

Understanding roles, relationships and embedding connections between different components of the system, as well as recognising how work in one area impacts another are important elements of combining a whole-system and locality-based approach. Throughout the analysis, developing and maintaining relationships across organisational and sectoral boundaries, and with service users/patients, was described as essential. Respondents suggested that while change under integration

had resulted in increasing management positions and the implementation rules and processes, this had largely overlooked the people delivering services, their roles/skills and relationships. Furthermore, they stressed the need to understand the roles of and to connect with those sectors/organisations which have significant responsibility in the field of Health and Social Care, but which are currently missing from integrated working at different levels of the system (e.g. independent care sector staff).

Finally, the analysis suggests that transformative change is necessary to contend with structural and cultural constraints of integration, but it is recognised that this would take time, requires relationship-building, a clear strategic direction and needs to be steered by the Scottish Government. Such transformation, the findings suggest, may be supported by combining a whole-system approach with a localities-based approach. The former requires a strategic view of the capacity of the entire Health and Social Care system in Lanarkshire, while the latter zooms in on local needs, resources and relationships. Understanding roles, relationships and embedding connections across and between levels of the Health and Social Care system are important elements of this. The focus of integration may, therefore, be redirected away from governance structures and processes, to include people and relationships.

Next steps

The findings from this research, along with the other research conducted as part of the CommonHealth Catalyst (more information on the GCU Yunus Centre's website) will feed into a policy briefing which will be available by the end of November 2023.

Contents

1. Introduction

Exploratory research was conducted as part of an AHRC-funded project to explore how the integration of Health and Social Care is playing out in Lanarkshire. This work gathered respondents' perceptions from across Health, Social Care, the third sector and from people with lived experience. It considered the following questions: what does integration mean; to what extent is integration taking place in practice; and what impact is integration having on reducing health inequalities?

These insights will feed into a policy briefing that is being informed by the various elements of the CommonHealth Catalyst project to inform future work seeking to support and facilitate cross-partner collaboration, especially at the level of service delivery.

This report provides brief details on the approach to research and analysis before presenting the preliminary findings. The findings are split into four broad sections: integration of Health and Social Care, focusing on the multi-disciplinary teams established within Health and Social Care Partnerships; the third sector and social prescribing, which explores the third sector's role and its involvement in integration; tackling health inequalities, which considers the impact of integration; and a whole-system approach, where respondents' aspirations for integration are discussed.

2. Research Approach

Interviews were conducted with stakeholders from across North and South Lanarkshire, with respondents selected through a snowball sampling strategy. In total, 26 interviews and two focus groups were conducted between February and May 2023. Table 1 below presents the breakdown of participants' roles; their identities have been further anonymised for reporting purposes.

Table 1: Interview Participants' Roles

	Health	Local Authority	Third Sector	Lived experience participants	Independent sector
Pan Lan	• Services Manager • Health Improvement Manager • Covid Rehab lead • GP Link Worker			• Focus group (8 participants)	
North Lan	• Health and Social Work Manager • Speech and Language Therapist	• Integrated Rehabilitation team lead • Locality Social Work Manager • Social work – senior practitioner • Senior Manager	• TS organisation funded through Community Solutions x2 • Third Sector organisation • VANL senior manager		• Independent Sector Lead for NL
South Lan	• ICST Team Leader x2 • District nurse • Health visitors focus group (4 participants)		• Third sector organisation x5 • VASLAN Project worker	• Lived experience participants x2	

This exploratory study has not looked at all aspects of integration and the sample is not representative, but rather it provides a snapshot with insights into the practice and impact of integration across Lanarkshire from different perspectives. Due to time constraints and the complexity of the health and social care landscape, insights from important stakeholders are missing from the analysis (e.g. GPs, organisations from the independent sector, social care staff from South Lanarkshire Council).

Data has been coded separately for each local authority area and organised in analysis tables. This allowed for some codes to be used across data sources, but also provided some flexibility to uncover nuances. Respondents with a pan-Lanarkshire perspective were also coded together to provide contextual insight. The preliminary findings are presented below.

3. Integration of Health and Social Care

3.1 Understanding integration

Respondents discussed what they understood by integration of Health and Social Care, how it is taking place in practice, but also what it should be. They mentioned a potential lack of clarity or agreement around the meaning of integration, saying it was likely that people would interpret the concept in different ways: "you can be absolutely certain that [integration] means different things to different people" (SL Third Sector C).

A few respondents said that integration referred primarily to the establishment of Integrated Joint Boards (IJBs) at a strategic decision-making level and the governance structures put in place to facilitate joint working between health boards and local authorities in Scotland. However, most offered a broader understanding of integration, suggesting it takes place at different levels of decision-making and service delivery and should include multiple actors, including the third sector. They said integration meant working together, exchanging knowledge and sharing skills to achieve common goals, and especially reducing duplication at a service level. A few also described integration as a locality-based approach, where local need, gaps in care and solutions are jointly understood and tackled.

> **"I'll just immediately think it's about working together. It's about people working together. So that could be across organizations or professions... But the other bit of it for me is... about the shared skills, the shared knowledge. So that that whole bit where... you might have spent two days trying to track down a physiotherapist, but now the physiotherapist is sitting right next to you when you come back from the visit. It's that sharing of skills and having easy access to each other."**
> **(NL Integrated Rehab Team)**

> **"... [Integration is about] coming together, sharing that best practice, and saying what do we need. It's every locality going right this is what we've got, this is what we're missing, this is what we need to improve, so who is doing what and we all just muck in together basically. We know each other, we know that you could pick up a phone [to] Health and Social Care, a third sector, a community, it doesn't matter, just pick up the phone and you know who they are and that's it. To me that's integration, we're all just working together."**
> **(Health D)**

Respondents described both the strategic direction of the Integrated Joint Board and senior leaders, saying that while the strategic intent for more collaborative working had been communicated clearly, further work was required to implement change. Some respondents also emphasised the importance of the role of middle management in enabling integration in practice.

> **"You've got to have a starting point, haven't you, and to have the Integrated Board is a signal that we're serious about this. That's important, that a serious signal needs to go out in that sector. And then the difficult bit happens, what is the signal in detail?"**
> **(SL Third Sector C)**

> **"That's the new drive through the Strategic Commissioning Plan. It is really that people in their communities should be involved.... You know, it shouldn't be driven by social work and health. It should be driven by people in their communities and that's really our head of planning. That's very much her vision and she's really quite passionate about that, and that cascades down through managers."**
> **(NL Locality Manager)**

3.3. Multidisciplinary Teams

In both authority areas, work had been done to establish multi-disciplinary teams (MDTs) with one respondent noting that "it's happening everywhere. And where it doesn't happen, it's a standout as oh, that's not great" (Health A).

3.3(a) North Lanarkshire Integrated Rehabilitation Teams

In NL, six Integrated Rehabilitation Teams – one in each

of the six locality areas – are in place which comprise of Occupational Therapists (OTs) and assistants from NL Council, and OTs, physiotherapists and assistants from Health. The first was tested in Motherwell, where it was described as running effectively, with professions co-located and therefore able to develop relationships, share information and work together during patient screening/ assessment.

> **"I'm really strong about that, about the person-centered approach and somebody not having to tell their stories 40 million times to all these different people... it's the right person going in at the right time to the patient in need, or their family or their carers as well, without having you do umpteen assessments and all these handoffs that go on. So that works quite seamlessly, I feel in Motherwell. I feel I've got very good contacts with my colleagues in Health."**
> **(NL Locality Manager)**

However, respondents from both NL and SL said establishing relationships by physically sitting with a team on a temporary basis was also useful because it supported understanding of roles and processes, sharing of information to support patient/service user screening and knowledge of who and how to contact colleagues from other professions.

Respondents spoke at length about job change for those working in Integrated Rehab Teams.

> **"In terms of what people do, an NHS OT and NLC OT had very different remits, but nowadays we're probably, there's a kind of a 80% core remit. And they've got a bit of like just 20% of what they would do is kind of specialist to either the NHS."**
> **(NL Integrated Rehab Team)**

Job change was viewed both positively and negatively. For example, referrals could be dealt with by any team member, providing a more flexible workforce and supporting learning. However, respondents said that other teams were not working so effectively due to reluctance to alter work practices and a feeling integration had been forced on staff with little consultation or support. The role of team leaders and their understanding of the differences between Health and Social Care roles was emphasised as crucial to supporting change.

> **"I'm not saying it works just as nicely in some of the other teams... they are having some challenges where people are saying 'I don't want to do it, that's not my job. I'm not you know... I'm an NHS OT and I wouldn't do that'."**
> **(NL Integrated Rehab Team)**

> **"... it seemed to almost happen overnight and I think the teams that were created as a response to the services coming together was kind of a bit of shock. We need all this and we don't have the infrastructure really to support it."**
> **(NL Speech and Language)**

Home Assessment Teams are also in place and should be working with Integrated Rehab Teams, but few respondents discussed these, perhaps reflecting work in progress with regards to integration.

> **"We should certainly have the Home Assessment Teams meeting regularly with the Integrated Rehab Teams. My understanding is they're gonna be brought together in each locality anyway, so they're almost building in a more integrated approach or multidisciplinary approach. But it should be expanded [and] the voluntary sector absolutely should be in there."**
> **(NL Third Sector Interface)**

3.3(b) South Lanarkshire Integrated Community Support Teams

In SL, four Integrated Community Support Teams (ICSTs) are in operation, with one in each locality. The ICSTs are different across localities, set up according to the local environment; some include healthcare professionals only (i.e. nurses, Health OTs, physiotherapists and assistants) and others include carers from Local Authorities.

> **"... in East Kilbride, it's part of the ICST because they've got home carers that work specifically with the district nurses... So East Kilbride have got four home carers that are employed by East Kilbride. [Camglen] don't. And Hamilton don't. I think Clydesdale might have carers as well but I think that's more because of the area, because it's huge... very kind of spread out."**
> **(SL Nurse)**

Respondents from ICSTs described how the teams worked well because members shared a health mindset, skillset and practices: "It was lovely working with the nurses and having physios. That all worked beautifully." (SL Health MDT B). Another respondent noted that the professions within the ICST had remained physically separate, but service managers from Health and Social Care were co-located which supported problem-solving, especially around hospital discharge: "they call it an ICST. And so it's nurses, physios, OTs as well. But we're still, I would

say we're still pretty much separate, to be honest." (SL Nurse). One health respondent who had worked previously in an integrated team with social work colleagues in SL, emphasised the benefit of being co-located and especially the ease of communication between professions:

> **"I think integration should be us all in one building. We should all be together… There shouldn't be you're Health, you're Social Work. It should be one big, nice building where we all sit and we all live and we can all speak to each other… That to me should be integration. Whereas at the moment, we talk about integration but we're still very separate. We're still very Health and Social Care."**
> **(SL Health MDT B)**

Although SL teams are predominantly health professionals, respondents noted that there was some progress to work with social work colleagues on collaborative short-life projects "to bridge gaps and improve things" (SL Nurse) in areas of high deprivation. Respondents also said daily meetings were taking place with social work colleagues to discuss and allocate support to patients being released from hospital. However, sharing responsibility across health and social care was constrained by separate governance structures and budgets and changes were slow due to organisational rules and bureaucracy.

> **"We started doing a bit of work with Social Work OTs. If we go out and we see someone who needs a stairlift and we've decided that's what they need, why do we need to then get a Social Work OT out to assess when we've assessed and we're an OT and you're an OT? The Head over there… was like, 'Right, okay… we can try and do a bit of joint working to try and educate you guys as to how to order one. Then maybe we can start to put that slowly into practice.' We've talked about this for about seven years … Nothing happens quickly because the budget lies in social work and I'm a wee Health OT… They know that my name is not a social work name. You probably could do it as a small pocket like they've done in an IRT, but actually I think we need to do it as a bigger project."**
> **(SL Health MDT B)**

Although respondents felt that generally ICSTs were working well, there had been previous attempts to merge Health and Social Care staff which were described as working less well. Respondents discussed the need to support teams with different professional backgrounds, to understand respective roles, skills and build relationships. They also said staff entering new roles needed time to understand governance structures and workplace practices and tools.

> **"… we're going… to shadow other teams and we're finding that they've not got enough space, there's no admin, they're really struggling. They came from social care [and] they don't understand supervision and how things work in NHS Lanarkshire. They're using audit tools that they're not familiar with, and it's given false outcomes…"**
> **(SL Health MDT A)**

Home First teams, comprising of health and social work, have recently been established to facilitate hospital discharge and provide six weeks of rehab therapy alongside home care. Although respondents recognised that Home First offered a potentially more seamless service for service users, one questioned the need for a separate structure, suggesting this resulted in a more complicated referral system for staff:

> **"The Home First team was set up literally overnight, but it's practically the same as ICST. Why not just put a wee bit more investment into ICST than create another team that people then have to think about how do I refer to them and is that who I refer to or is that who I refer to. I don't know. Sometimes you just think they come up with ideas."**
> **(SL Health MDT B)**

3.3(c) Relationships and learning

Respondents working in MDTs talked about the importance of establishing and maintaining relationships to support integration: "a lot of it is around the power of relationships and about knowing what's going on and how do you connect." (NL Senior Manager). Knowledge and understanding of different roles were regarded important, with knowledge exchange through day-to-day interactions, during team meetings and via short life working groups mentioned frequently by Health and Social Care respondents.

Relationship building between professionals from Health and Social Care was described as essential at all levels. For Health and Social Care respondents, two types of relationships were emphasised: day-to-day team working to conduct screenings and ensure services users were allocated professionals in the community with the correct skills; and knowledge exchange with those from the same profession to support development, and with other professionals to help understanding of roles/remits and learning. Respondents frequently mentioned misunderstanding from other professions of what their role was, which was regarded as a barrier to joint working.

> "... there's been an element of Acute staff not understanding what can be provided in community. But even broader than that, they don't quite understand what the community and voluntary sector can offer as well, and why helping connect people with their communities can be of huge benefit too."
> (Health B)

> "What you would think is relevant to share might be different to what I think is relevant to share in terms of that case. We probably would have the same, but Social Work might have different ideas of what they should share with you, because they probably don't understand a lot about our role."
> (SL Health Visitors)

Although different approaches were taken in NL and SL, for both MDTs, the quality of the referral from GPs and staff working in Acute and communication among professionals during the screening process was important to ensure people received the correct support. Nevertheless, the different structure of MDTs was described as making the referral process more difficult for colleagues making referrals, which respondents said could lead to duplication.

> "... we get these referrals in from a band 5 therapist and University Hospital Wishaw. And someone will say, I mean, what's that even coming to us for? That's coming to us because this poor wee soul is dealing with North and South, different areas of South and it's so confusing... we need to let that person know or we need to say, do you want to come and shadow us, do you want to spend time with us, we need to invest in people. And I think when we really, we need to invest in people."
> (SL Health MDT A)

Lived experience respondents also discussed how a lack of understanding of roles impacted the advice they received and could result in an inefficient service pathway where people are directed to the wrong services:

> "If you've got a social worker or a home support worker, that's the information they'll give you is outwith 96, go to A&E, contact 111. If you contact 111 the chances are they will tell you to go to A&E. That's where people are directing to. I always found just how disjoined it was."
> (Lived Experience A)

Developing relationships was also emphasised by lived experience respondents. They reinforced the importance of building continuity and trust with service providers by, for example, having the same carer as far as possible.

> "... they're not chopping and changing people all the time, so you're coming in and they've bandaged the wrong leg or something, because they don't know. Because again that blue book is not always filled out... I'm just saying that on my mum's basis... for elderly people, it's just themselves and they're getting 10 different carers come in... They don't get that bond, you know, they don't get that trust built on anything, they're just: 'Oh, another stranger!' And honestly it's pretty brutal how some of them are treated as well."
> (Lived Experience B)

3.4 Constraints on Health and Social Care integration
All respondents emphasised the constraints on Health and Social Care integration, with four clearly identified.

3.4(a) Separate budgets
First, separate budgets were recognised as constraint to integration. Expanding on this, respondents working in Health explained that budgets are allocated to professional areas (e.g. physiotherapy) which encourage staff to plan and deliver services in professional silos rather than collaboratively. One respondent also spoke of the need for greater consideration around how resources are allocated, but recognised that change would be challenging.

> "And if you wanted to do something that was a multidisciplinary team then the question is where does that money come from because physio say well it shouldn't come from physio ... So, you end up never really having any true direction because we don't take a whole systems approach. We think in silos."
> (Health C)

> "And also like again just my perception that any shift of budget that is coming through. It's not coming through maybe more of the medical and health professions. You know it is coming through Public Health or Health Promotion... certainly the idea I suppose of anything coming out of, for example, my budget and moving into the community and I mean that would that would be viewed as ludicrous! But actually when we're talking about this, we're not creating new money pots so if we're gonna do this, we have to use the finite resources we've got and shift that over."
> (Health A)

Health and Social Care respondents from across Lanarkshire also agreed that due to increasing service demand and tightening budgets, there may be a tendency for professional areas to protect individual budgets which could hamper future collaborative working.

> "I would hope that given that we're in this sector that what you would say is it's about the best thing for people. I would hope we would all say that and to be honest, I've not heard anybody not say that... I suppose by human nature, you want to protect your own bit, don't you? So it's like that's my budget, that's my resource.
> (NL Senior Manager)

3.4(b) Separate IT systems

Second, respondents emphasised the challenge of working with separate IT systems for Health and Social Care employees. Some mentioned that although new systems had been or would be rolled out for both disciplines, it was too expensive to develop an integrated system. Those working in MDTs spoke at length about the manual workarounds they encountered as a result.

> "Oh yeah, IT was a hoot. You would phone IT to say this is not working. Well, who are you? I'm an OT, I work in social work but I'm actually a Health OT. Oh well, you need to phone Health. No, because it's a Social Work error and it's not Health error. One day one of my colleagues monitored it and within a whole day's period, she works 8.30 to 4.30, she spent only one hour not on the phone sorting out IT and communication issues because the systems don't talk and because we were Health and not Social Work... If we needed to do anything Health we had to then come over here. The amount of times we would spend walking between the two buildings to do that... That fundamentally for me was what broke it all down."
> (SL Health MDT B)

Those with lived experience also discussed the negative impact of disconnected IT systems, saying it resulted in them having to tell their story multiple times and highlighted inefficiencies in the current system.

> "I don't feel like it's joined up at all. From a carer's perspective and having supported my gran at a number of appointments over the last few years, you go to every appointment, you are brand new, you have to start over again. Tell the story, where you've been, what you've done, who have you spoken to, what tests have you had. It's almost like that piece of information that you've spent telling 20 other people, it's almost like you might as well not have bothered because it's either not recorded anywhere or if it is, nobody has bothered to read it."
> (Lived Experience A)

3.4(c) Separate governance structures

Third, separate governance structures were described by various respondents as constraining integration. Respondents suggested that the inclusion of Health and Social Care Partnership and the Integrated Joint Board on top of longstanding Health and Local Authority mechanisms further complicated governance. They also emphasised that sharing information across each area was not straightforward, which links back to the previous point about separate IT systems. Furthermore, for Integrated Rehab Teams in NL, two sets of policies and procedures were used for staff, which complicated the role of line managers and has resulted in Trade Union involvement. SL respondents also mentioned the recent move of Local Authority employees into Home First teams, emphasising that job change required careful negotiation with staff, which could slow integration.

"... we still separate governance structures. So we'll have Councillor Board and then we'll have an NHS Board and then we've got an Integrated Joint Board. And so it can be very complex so it's not as integrated as it probably should be. Integrated teams, integrated systems because data protection becomes an issue, who owns...."
(NL Senior Manager)

"We work in a community and things can be a bit easier, but there's all these terms and conditions that the SYOTs would sign up for, and now they're moving base. Their role is changing and that's a real challenge for them."
(SL Health MDT A)

3.4(d) Entrenched cultures

Finally, entrenched cultures, mindsets and ways of working were a barrier to integration. Health respondents working in MDTs spoke of having to negotiate and compromise with colleagues from Social Care because they come from different perspectives and have different ways of doing things. Respondents from Health also discussed the legacy professional groupings and said that groups wanted to maintain their identities and retain their core skills. They reflected that integration might threaten those identities.

"The NHS... is very segregated, there are a lot of silos. And that's nothing to do with the Health and Social Care Partnership, that's to do with how it was done historically... each profession is like a bubble and they don't really want you to bang into each other in case the bubble pops. What you find is some professions want to ... and they often will blur into other roles."
(Health C)

"I think there's a lot of anxiety about that whole overlap of your professional identities... I think we're very clear in the fact that this is what an OT does and this is what a physio does but there's this wee grey area that we both can do. Whereas I do wonder whether there's a degree of anxiety that people will take people's jobs, so to speak."
(SL Health MDT B)

4. Third Sector and Social Prescribing

4.1 Third sector role

Respondents unanimously spoke of the third sector playing a 'low level', foundational role which was crucial in improving population health and wellbeing and in supporting objectives of integration around early intervention and prevention.

"... it's lower level support which we would argue would be prevention and early intervention... Somebody has, I don't know, fell and broke their ankle, for instance. And then can I get some shopping? Is there something locally that somebody can help them to do that stops them being isolated, stops poor mental health, make sure that they get to their follow up appointments and are not missing them... that kind of stuff that then doesn't become that we'll end up treating somebody that costs quite a bit of money around mental health because we didn't support them to manage to get their shopping. So they become ill, they're not eating, they're not picking up medication."
(NL Senior Manager)

Most respondents clearly differentiated between the role of third sector and statutory services, explaining that the third sector offers flexibility and social support, especially for more vulnerable groups within society. This was emphasised by respondents with lived experience who discussed in depth the "more human element" advocated by the third sector. Respondents mentioned ease and flexibility in accessing the service when needed and having someone to talk to.

"It makes a world of difference. Again, to just be heard... they might not necessarily be able to help you... but even if they help you a wee bit, and they listen to you, they're like, 'Right, well we can put you in touch with somebody that can help you' and I think that, just by itself would make such a difference."
(Lived Experience B)

"I said, 'I'm not looking for medication, I don't want medication. I want somebody to talk to, somebody to listen to me, and see if they can help me that way'."
(Lived Experience C)

A couple of third sector respondents noted a concern that integration could result in statutory sector rules being imposed on the third sector. They said that training they

were required to do was often not relevant as it related to approaches the sector has taken for some time.

> "We don't give it names like Trauma Informed Practice or, you know, we don't give it a name like social prescribing... And in practice we've already been doing it, but now what's gonna happen and it's like anything that's come through NHS and councillors... as soon as it's endorsed by NHS and Council, that's it, it's the bee's knees... Our staff are going to be doing this, that. But forgetting all the while that informally, the third sector have been doing this for years. And my worry is that what we'll do then, is they'll impose some formal training on to third sector so it aligns with their systems and practices."
> (NL Third Sector C)

Although there was a narrative of partnership with the third sector, the MDTs in both local authority areas were not working in partnership but referring onto third sector organisations. Health professionals spoke overwhelmingly positively about the third sector, with all suggesting it has an important role to play in terms of referrals for social support, with many mentioning national charities (e.g. the Samaritans) and a few also local organisations.

> "I would say that [the third sector is] part of integration and it's happening and discussions are being had, but we're not there yet."
> (SL Health MDT A)

While the third sector was widely respected and regarded as providing crucial services, a couple of respondents reflected upon the capacity of the sector to deal with complex needs and increasing demand within Lanarkshire. They mentioned that cuts in statutory services had put pressure on third sector organisations to fill gaps, but some respondents said organisations were not equipped to deal with complex cases such as dementia. Respondents from across sectors were concerned that need in Lanarkshire was not being met.

> "... when somebody has got dementia, we can do the early onset stuff, but once it gets a bit more severe and they're needing more support, we have to contact the family and say, 'I'm really sorry, this person needs something more than we can offer', because it's volunteers that are doing those services, and we're not a care provider. As much as we have health and social care and we have health impacts we're not a care provider."
> (SL Third Sector E)

> "I think that's possibly the issue that they've got this little group of pretty able people. That they can engage with, and it's easy going, and it's no too much a hassle, and they don't want anybody rock that boat and make that and make that job that they've got more difficult. And the people that I work with who are pretty far on in their dementia. So that that might be a challenge for them."
> (NL Social Work)

Instances of the third sector being unable to offer adequate support were also discussed by those with lived experience, particularly where those offering particular services were not trained to do so. Overall, lived experience respondents spoke of the difficulty in finding an appropriate service provider.

> "It was out of hours. They've got a crisis line. I phoned them up and they said we're not mentally health trained, you'll have to phone the Samaritans... I said to somebody why are they a mental health charity when they've got no mental health training. That's crazy."
> (Lived Experience A)

Furthermore, transport was mentioned frequently by Health and Social Care respondents as the main barrier to people, and especially the older generation, accessing third sector services.

> "I don't feel anxious about someone from the third sector. I don't feel there's any barrier. I think for me, I feel the main barrier is we can't get our patients to them."
> (SL Health MDT B)

> "It's a huge gap. Yeah, it's. If you've not got family that are willing, able to be there on a certain day to take you to a certain group, to sometimes have to sit with you during that group. To then, bring you back. You ain't going."
> (NL Social Work)

4.2 Visibility of third sector organisations

The landscape of third sector organisations was described as ever-changing and different within every locality, with local organisations often invisible to those working in MDTs or to people needing services.

"I think we know as much as we know but I think there's a whole world out there of third sector stuff that we could really be utilising. We try to find out the information but, again, if they were integrated with us, if they were with us in a building, we wouldn't have the same stresses. I know that's a glorified world but you just think integration isn't integration because they can't get in here and we can't get in there."
(SL Health MDT B)

"There is so much stuff happening that people don't know about."
(SL Third Sector D)

"Respondents with lived experience also spoke at length of having difficulty finding third sector organisations and of Health and third sector professionals alike not knowing which community organisations could be referred on to. Well, some doctors don't know about charities you can go to. They'll go with like the standard Samaritan, 'Have you phoned the Samaritans, have you phoned Breathe…', and that's it. It's literally took myself to research some charities… but if you're someone, I was just lucky I did at the right time… but if you don't, you're lost, you really are."
(Lived Experience B)

Various respondents recommended that a central point through which to access third sector organisations would be beneficial. While some mentioned that an online database was available, others said the information was out of date with some organisations not included.

GP link workers are in place across Lanarkshire to support social prescribing and have each gone through an induction programme, which includes time to make links and build relationships with third sector organisations. Continuous work is also being done to map the third sector landscape and to share this information across GP link workers. However, SL was perceived as more difficult to navigate compared to NL, which has consortiums in place to bring together local actors (see section 4.4 for further details). Third sector respondents from SL were critical of the GP link worker model. Some were unaware of GP link workers being in place and others thought that they were not fully versed with the local third sector landscape. There was also a strong perception among third sector respondents across Lanarkshire that funding could have been better utilised by investing in services to respond to increasing demand, rather than signposting. Respondents were particularly concerned that increasing referrals into their services had not been accompanied by matching investment from the government (discussed further in section 4.3).

"… the difficulty with the GP link workers is they're not connected into the wider Community Solutions program. So they are just if you like, referring to community supports, whether there is capacity there or not. And that's where the danger is that it breaks down. It's like you know, you can't just keep on referring, referring, referring without actually being aware of what the capacity is on the ground."
(NL Third Sector Interface)

"any funding that has come through so far, has already been signposting, and we keep thinking, we don't need, yet another person to tell them to come to us, we need money to make sure that we're still here… "
(SL Third Sector E)

"there's no time within their job role to go out and be able to speak to organisations or even dedicate time to find out what organisations are there or even building relationships with people. It's not in their remit, they don't have the time."
(SL Third Sector D)

There was a perception among respondents from the statutory sector that fewer third sector services were available since the pandemic, although they also noted the challenge of finding time to network and the need for knowledge exchange with the third sector. Likewise, third sector respondents discussed at length the importance but challenge of finding time to network with each other and with other sectors, particularly because such work was not typically covered by funding.

"The demand is quite different. And I think that's where I feel people are just like working, working, working… And it's like trying to say to teams, you need to take time to read the emails that come and take on the opportunities. Because if someone sent something out and it is about a third sector service, you know, can we work this out? Could at least some people go on it and then we'll share it at the team meeting? Do you know it's just everybody's like 'Oh I don't have time to do anything because we've got all these people to see'."
(NL Integrated Rehab Team)

> "Organizations wanted networking, they want to get together face to face. They want to support each other. Want to learn from each other. They want to collaborate."
> (SL Third Sector B)

4.3 Third Sector investment

Third sector investment from across Lanarkshire emphasised the increasing demand placed on third sector services, which has not been matched with investment. They clearly explained that there is often an expectation that the third sector would deliver "something for nothing", but said that demand was outweighing capacity, which along with other pressures such as increasing costs for energy, threatened the survival of third sector organisations.

> "I think the issue that we have is that there's demand on our service like never before. Third sector organisations are going to disappear. And we're not for free."
> (SL Third Sector B)

> "That needs resourced. So you have partners, Health Improvement partners, Health and Social Care partners referring into [us] all the time. But there is no resources to follow it."
> (SL Third Sector A)

Some SL respondents also reported that certain third sector organisations could no longer be referred to due to cuts in funding, resulting in a postcode lottery to access important services. Even within local authority areas, respondents discussed the variability in services available from the third sector.

> "I think it is a bit of a postcode lottery. I think the whole of Lanarkshire... I think within this area I would say the service you get here in comparison to Hamilton or Camglen or Clydesdale is totally different. I think it is the luck of your postcode."
> (SL Health MDT B)

Overall, there was agreement that a bolder approach to investment was required to adequately fund the preventative and early intervention services offered by the third sector. However, respondents also noted that this required transformative change to models of resource allocation.

> "It just takes that bravery to go, right, okay, we'll invest it now. Because see the time and the resource that they've saved by pumping them out quickly and not having that conversation, see when he bounces in three days later with an infection and he need to be admitted and he needs surgery to amputate half his leg, how much is that going to cost? Because it would probably cost more than if they'd just invested the time the first time."
> (Lived Experience A)

> "I think there is a huge role for third sector, I just don't think we utilise it very well and I don't think they have enough investment in them... they need investment to be able to provide what they want to provide."
> (SL Health MDT B)

> "Social isolation is such a massive driver of anxiety and depression and... we [need to] really hammer home that that's preventative spend. But we're at the bottom, we're on the bottom drip tray, if you like, even though it's preventative spend."
> (NL Third Sector B)

NL's funding model, Community Solutions, was typically described as unique and received positive reflections from both statutory and third sector respondents. Under Community Solutions, funding is allocated through each of the six locality hosts, which are responsible for distributing resources to fund local activities and build capacity in the third sector (£30,000 for each locality per year). In addition, £500,000 is available for a NL-wide thematic programme, which aims to plug gaps in services and £600,000 over two years through the Improving Lives Initiative to expand work with communities. Although respondents noted that the investment was small in comparison to the overall Health and Social Care budget, they said it directed money into the third sector and highlighted the willingness of the Partnership to work with the sector.

> "So it's significant investment. But the communities or those third sector organisations will say that's tiny in comparison to the overall budget and it is. The reality is it is, but it's testament to the commitment or them being valued partners in that."
> (NL Senior Manager)

> "Without [Community Solutions], I think our perception would be different that we would still be seen as the tokenistic partner, to be honest. So not, not fully involved in anything and I think the Community Solutions program has helped improve those relationships with statutory partners."
> (NL Third Sector C)

However, a respondent who did not work in a host organisation had a different perception and questioned the method of distributing resources in NL, suggesting this could be done more fairly.

> "There's a huge inequity in the way that the Health and Social Care Partnership localities are set up in that the north area has 91,000 people, but the same resources as the other localities. But none of them even have half that, I don't think, so there's a little kind of legacy in inequity there that all the groups that I work with are really fighting against."
> (NL Third Sector B)

Respondents in SL said that there were discussions currently about how to better allocate funding into the third sector. Third sector respondents, in particular, emphasised the need for investment in long-standing projects that were of value to the community, but which have often never been funded by Health and Social Care Partnership. Some respondents also criticised the current project-based approach to investment as too short-term and lacking foresight around delivering sustainable services to meet need.

> "... it's not about you giving us money to do new projects, it's about you giving us money to sustain what we already do, which you're already getting the service delivered, that you're not invested in, you need to invest in it..."
> (SL Third Sector E)

> "... with the consortiums giving out money my thought was always that's a great project but what are they going to do when the money runs out because we've given somebody something that they're going to love, they're going to benefit from, which is really going to make a big difference to them, but when that funding dries up where is that person going to go after that?"
> (Health D)

4.4 Third sector engagement and representation

Third sector respondents from both NL and SL expressed concerns over their lack of representation at a strategic decision-making level. They were especially concerned that the community voice was being lost at the level of Integrated Joint Board and that the mechanisms in place for engagement were tokenistic. Indeed, respondents from the third sector typically did not feel like an equal partner in the decision-making process.

> "... we've been at this a long time. We're having the same conversations over and over again. So we don't know who actually makes the decisions, and presumably the Integrated Joint Board. And that's two different sets of folks who I don't know what the community input to that is it... You know, are we being represented by a Third Sector Interface who don't speak to us? They're just giving their opinion then?"
> (NL Third Sector B)

> "The third sector, almost their involvement is tokenistic. It is not viewed as being an equal partner. And not viewed as being essential and it's an afterthought. It's a tick on paper that we've engaged with VASLan... We're the ones that the grassroots, we're the ones that community level. We know what the issues are..."
> (SL Third Sector A)

Although it was recognised that VANL and VASLan are represented on the IJB, some third sector respondents questioned their representativeness of the sector or of the various thematic areas discussed at the strategic level. They suggested that those with valuable expertise were not typically feeding into the decision-making process.

> "I don't always think that the Third Sector Interface are the right people to drive some of the agendas forward. And I'm not dissing VANL and the role. I just think that sometimes they're disconnected from the communities themselves as well... I sometimes think that maybe not for the next three years, but maybe beyond the three years, that Community Solutions programs should look at funding [host organisations] directly. Rather than it being funnelled through VANL and asking them to take on some of the thematic leads."
> (NL Third Sector C)

In response, a Chief Officers Group was established in SL. The anchor organisations attached to the Chief Officer's Group run Locality Networks on behalf of VASLan to support community engagement, but respondents continued to express concern that the voice of communities and the third sector is lost during strategic decision making partly because current engagement structures are ineffective.

> "I suppose they would say, 'Well, we've got the forums, so all these organisations are welcome to come to the forum to have their say', but do they all know about the forums? ... there's a whole load of work about, getting the right people round at the table, but it hasn't worked ... I don't know how you get that to work, so that everybody who should have a voice, does. That's quite a difficult thing."
> (SL Third Sector E)

In NL, host organisations funded by Community Solutions run consortiums in each locality which aim to bring local actors together to discuss community needs and to assess and distribute a small fund of £30,000 each year to local groups. While the consortium is open to any third sector organisation, only invited third sector organisations can attend Locality Planning Groups, which re-commenced in May 2023 after a hiatus during the pandemic. The onus is therefore on the ability of the host organisation within each locality representing other third sector organisations and the community to feedback to VANL and the Integrated Joint Board. However, respondents noted that the current mechanisms in place to capture community insights were not necessarily fit for purpose.

> "It's difficult to get people to engage and it quite often always the same faces... I think people just feel as if I'm not going because nobody is going to listen to me."
> (NL Third Sector A)

> "... we've been working with our locality host for the last four years trying to get better third sector representation and better hearing of ideas."
> (NL Third Sector B)

4.5 Locality-based approach

There was recognition from various respondents of a shift in strategic thinking towards a locality-based approach to support goals around early intervention and prevention. In NL, respondents said Community Solutions funding directed resources into localities via host organisations and also pointed to the narrative within the Strategic Commissioning Plan which emphasised a locality-based approach. In SL, by contrast, one respondent said that while there was recognition of the importance of the third sector and some rhetoric around committing resources, this has not been followed by shifting budgets.

> "So I think that there is a bit of a drive to try and... Almost that place-based approach so that people can access things when they need them on their doorstep, that if it works properly and we do it properly and invest in it properly, less people should need access to statutory services. Or they don't just reach us at crisis point"
> (NL Senior Manager)

> "[There's] definitely a locality-based approach, the recognition that they [the HSCP] can't do what they need to do. They're stretched. They're underfunded and all the rest of it."
> (SL Third Sector B)

However, the analysis suggests a gap between the call for a locality-based approach and its practice.
As discussed previously, third sector organisations were typically described as being positioned as arm's length service providers which are referred on to and which are removed from strategic decision-making. Respondents also pointed out the constraints on achieving a locality-based approach, including the challenges of re-distributing budgets away from professional groups in Health and of overcoming power relations which are embedded through the commissioning model and accountability requirements imposed on the third sector.

> "... in terms of how budgets are aligned, management's aligned, it's all kind of conditions [that are] profession-specific and you know wanting to build multidisciplinary integrated hubs, that becomes this quite complex network that's usually relational, not budget driven... So that I think the kind of gnarly bit... That is a barrier and absolutely both for the partnerships and the NHS, the consideration of well, how do we shift budget into our community? How do we shift power?"
> (Health A)

Those who regarded the third sector as an important partner in the integration agenda spoke of the need for further progress towards a bottom-up approach. They recognised that in practice, further work was required to understand the capacity of the third sector and how it can contribute to Health and Social Care goals. Some respondents also suggested that building relationships with the third sector during service delivery and decision making was important to support a locality-based approach. There was recognition that further work had to be done to achieve this in practice.

> "To be integrated, they need to be listening from the ground up, to everybody who works with people who are challenged by health inequalities, so that their priorities are meeting that, and I don't think that's what's happening... I hadn't even thought about private healthcare providers, who is speaking to them? They need to be integrated into the system, they've got a wealth of knowledge, about their community that's not been fed into anybody, so there's a whole cohort of people that aren't even being considered, are potentially being missed."
> (SL Third Sector E)

It was unclear from the data whether community need within localities is clearly understood and the extent to which this informs the planning and delivery of services. However, one respondent said the different strategic goals of the Health and Social Care Partnerships impacted the extent to which community need was prioritised, with NL considered to be more willing to take financial risks to meet clinical demand. Another respondent also suggested that understanding need at a localities level was not sufficient because there were stark differences in need across neighbourhoods.

> "What we identified again was that if we were going to make a real difference... and tackle isolation and loneliness, which is a huge problem and get people back out their houses and support them and stop the issues of frailty and inequalities and discrimination and all the rest of it, we had to tackle it by neighbourhood. It's too big... we would dilute the effect."
> (SL Third Sector B)

5. Tackling Health Inequalities

5.1 Disconnect between decision-making and practice
Reducing inequality was recognised by respondents across Lanarkshire as a fundamental strategic goal, with respondents from NL in particular saying that the Strategic Commissioning Plan reflected a shared desire to reduce health inequalities. However, there was less clarity regarding how inequality is being tackled in practice. Respondents working in service delivery across Lanarkshire emphasised a disconnect between decision-making and practice. This reflection was linked to an argument for increased government investment in the third sector's early intervention services, but also a general perception that decision-makers were too far removed from day-to-day service provision, local need and the challenges facing the Health and Social Care workforce. As a result, respondents said ideas regarding integration and on how to reduce inequality did not necessary fit with workplace practices or processes.

> "... for me there are great ideas about at that level way above my pay grade I don't think they filter, or by the time the filtered down they're not as good or they just don't filter down right."
> (NL Social Work)

> "I just feel as if the world in Health and Social Care is so reactive just now and if people would just be really honest and if the people on the ground would be listened to... I just feel as if we're managed by a lot of folks who just don't get it. And there's a pressure above that ... they have to come up with solutions, but they're not really, it's not solutions for the rest of us working in the ground."
> (SL Health MDT A)

Inequality and deprivation were described as clearly visible by various respondents delivering services, but they explained that deprivation was variable even within locality areas and is often hidden and difficult to target. Furthermore, the data did not clearly evidence how statutory services were responding to deprivation, other than managers encouraging frontline staff to take a holistic view of the service user and their environment, which many respondents delivering services already described as part of their job.

> "... when you're out in somebody's home, open your eyes, look wider, look at, you know, is there food in there, because if our people aren't eating and they've got a wound that wound is not going to heal because that needs nutrition..."
> (NL Health and Social Work Manager)

> "There's many a time I've bought food for patients and we've done all that kind of stuff. It's not my job. No, it's not. Equally, I can't go home at night and know that they've not got something that they need."
> (SL Health MDT B)

One respondent did, however, speak about the lack of organisational support to contend with inequalities that might be identified at a service level. This suggests that tackling inequalities is not embedded into work processes and goals.

> "I think that's my biggest gripe with the inequality pieces is that there isn't any organizational support around it. You're kind of just left to identify it by yourself, solve it by yourself. And actually if you don't solve it,

> no one cares... I don't know the authenticity, I suppose around that approach is not great."
> (Health A)

5.2 Dealing with the complexity of inequality

There was recognition from most respondents of the complexity of health inequalities and the multitude of social factors contributing to this. Respondents suggested, therefore, that more integrated thinking with other policy areas (e.g. housing, planning, transport, education, employment) was necessary to reduce inequalities and positively impact population health.

> "It's like you can't thrive in these villages with no infrastructure and poor housing and a lack of qualifications coming from the schools because the schools have given up... And then these communities are the ones targeted by austerity policies."
> (NL Third Sector B)

The analysis further highlighted the challenge of delivering Health and Social Care services for the population while also seeking to reduce inequalities. Respondents from across the statutory and third sectors emphasised high demand for services and the rising complexity of need within Lanarkshire. They said that there was not enough capacity within the system to deal with demand and even less, therefore, to contend with inequalities.

> "I'm not quite sure how you tackle inequality at the moment because it's how does a system that's on its knees tackle inequality, when one of the first things that will suffer is inequality?"
> (SL Third Sector B)

The complexity of service pathways was also noted by various respondents, who said vulnerable service users found it particularly difficult to access and navigate the Health and Social Care system, which had multiple barriers impeding access. Respondents with lived experience and those from the third sector also clearly expressed the challenge of accessing GPs in certain areas. This is likely to have an adverse impact of accessing GP link workers and social prescribing.

> "... we live and breathe this system, we know how painful it is and how awful it is... one of the girl's mums is currently in hospital and she's fighting against social work something frightful. She knows the system and she's still hugely frustrated by it. She knows it, so imagine if you didn't know it and you didn't have someone in your corner shouting for you. You're just left, sadly... I think too complicated..."
> (SL Health MDT B)

There was also some discussion from respondents about where responsibility for health and care falls. Statutory service providers were clear that self-management by service users/patients and support from third sector services was important.

> "And some of it, we have to pass back to the patient about self-management. You know whether it's as you say, accessing third sector beyond their therapy and beyond their treatments to help us sustain improvements or to help prolong good health, things like that. And that can be tricky when we're saying, you know, that's up to you now. And I think that's maybe where it falls down a little bit that things maybe aren't maintained beyond treatment or therapy."
> (NL Speech and Language)

By contrast, third sector respondents and those with lived experience clearly articulated the vulnerability of some service users and their need for additional support, 'hand holding' or changing service provision to overcome the barriers to services and to help limit cycles of inequality. This suggests that certain services may need to be re-designed from the perspective of the most vulnerable. This reflects a point made earlier about the third sector being viewed as better understanding need and offering more flexible services.

> "They keep putting all these things in place, but they don't actually take that person with the hand. And it's almost like, you don't fully understand mental health issues, and if you think telling somebody to go somewhere and make a phone call it's going to solve that person's problem, it's not. Some of them need to be handheld."
> (SL Third Sector E)

> "When you get into adults' services it's just like go your own way and find it out yourself. You have to advocate for yourself. Or you need to find somebody usually from the third sector to do that for you."
> (Lived Experience A)

5.3 Impact of integration on reducing inequalities

Respondents considered the impact of integration and whether it was enough to improve population health and reduce health inequalities. While some recognised improvement in specific areas, they mainly spoke of changes to ways of working which reduced duplication, enabled joint working in MDTs and helped free up hospital beds, rather than reducing inequalities. They were reluctant to say that changes had been felt by communities/service users/patients because of integration or that person-centredness had improved. Some respondents also noted the tension in achieving both goals of integration

(i.e. efficiency and person-centredness). They said the emphasis of integration was on discharging patients from hospital as early as possible and a focus on the capacity of the system (especially Acute) rather than needs or people.

> **"I think if we talked to the staff in [from the third sector] who are out there every day working with people, they'd likely say not much [benefit from integration]."**
> **(SL Third Sector C)**

> **"... when it's all about efficiency and maximizing what we can get out of resources and when we know the system is under extreme pressure, I query how person-centred we can actually be. Because if I'm a physio and I've got ten-minute appointment for you. How much can I get into: how are you? How's this working for you? I'm immediately thinking right, we've got seven minutes left. OK, just stop the chit chat, I need to get on with this."**
> **(Health B)**

Statutory sector rules and bureaucracy were also mentioned by respondents, especially with regards to the impact of integration on the goal of person-centredness. One respondent, for example, discussed how the pressure placed on Social Care employees negatively impacted the service experience because developing a caring and compassionate relationship was neglected as a result of adhering to bureaucratic rules. This suggests a need to reorientate towards work practices which deliver value for those using services, rather than simply on adhering to rules, although this is likely to require a careful balance.

> **"... when you've got a system that's so stretched, let's use Social Work, for example, and you hear social workers saying I'm burnt out... On the ground, the other perspective of our users' experience with Social Work is poor because: a. they don't get the same social worker; b. they have to relive that trauma time and time again; c. sometimes they're told 'oh that's no my job, off you go'; d. they're sometimes expected just to know things and social workers can bamboozle them in language... Their experience is really poor ... they've got so many, you know, risk assessments or protocols to follow to keep the population safe. The impact of that is that the empathy, the understanding, the whole person approach where they look at the whole person and they're trying to give them... is missing."**
> **(NL Third Sector C)**

Similarly, respondents with lived experience also talked at length about the importance of receiving services from providers who are compassionate and caring, suggesting that the way the system is set up and its goals do not support person-centredness.

> **"... just now it's like it's a conveyor belt... getting through the door as quick as we can and out the door as quick as we can. We've not got the time to help with mental health. Other people or other departments should do that, but where are those other departments?"**
> **(Lived Experience A)**

While all respondents agreed that reducing inequalities was a strategic aim, they noted that this played out differently in practice because each actor has a different understanding of what inequality is and its causes, and some are more focused on delivering for the population rather than vulnerable groups. Respondents reflected upon the need for more qualitative indicators to better understand inequalities, need and service experience.
They said that quantitative measures and political motivations often redirected focus away from inequalities and person-centredness.

> **"You get asked for information on how things are going because boxes have to be ticked and monies have to be accounted for. And when you're a clinician yourself, it's what is this experience like for the patient? That's where we keep getting taken back to... But sometimes at a higher level it's so how many people were discharged? How many hours therapy time do you think you know were reduced or home care was reduced? And I think that's the biggest challenge is then trying to balance that and manage expectations."**
> **(SL Health MDT A)**

6. Whole-System Approach

6.1 Importance of relationships

Although all respondents emphasised the constraints on integration, there was strong reflection that joint working through integration was a normatively good thing, which was difficult to measure due to its relational aspects. Respondents also described what integration should be rather than how it is taking place in practice, emphasising that it could be further developed and embedded over time, which they recognised needed transformative change to overcome structural barriers. In its current form, respondents tended to describe the governance structures associated with integration as being placed on top of existing structures, with friction between the two. Some also noted that adding new structures, such as a National Care Service, would increase tension further and would not necessarily improve health outcomes for individuals or communities.

"Well it should be [reducing health inequalities], if it was truly integrated. I think the problem is it's not truly integrated for all the things that we've said... funding, money available, people's willingness to shift."
(NL Senior Manager)

"I think the idea and the concept of integration could be helping possibly more than it is..."
(Health D)

Various respondents from across sectors suggested the whole system of Health and Social Care needed to be considered to deal with heightened demand, increasingly complex needs and to counter fiscal pressures. However, respondents clearly articulated that such a systems perspective should not be limited to governance mechanisms, rules, processes, referrals and procedures, but should consider relationships, supported by open communication across organisational/sectoral boundaries at different levels (e.g. local services, regional services and with local third sector organisations). As discussed previously, respondents also recognised that inequalities arise in a complex societal backdrop and cannot, therefore be solved by Health and Social Care integration alone. Government responsibility was described as essential, as was the contribution of the third sector.

"I think you absolutely need to look at trying to take it to a whole systems approach. I can't see any other [way] ... because that's only where you will truly get everybody all going in the same direction and having awareness of where we fit in that whole ... And until you change that I think a lot of it is just thinking around the edges. And if you're going to get true integration you need to be truly integrated. And that sounds really obvious."
(Health C)

"I think you know more relational... You know, working together as colleagues, part of the same team, equally weighted. I think that's where the solutions are."
(Health A)

"I think if they'd only sat down and looked at the whole integration agenda before they instituted it, they would have realised it's about the people."
(NL Independent Rep)

All respondents regarded the third sector as an important contributor to the integration agenda as was previously discussed in section 4. However, there was general agreement that while inroads have been made in terms of Health and Local Authorities working together in MDTs, the third sector is "bolted on" and is used for onward referral rather than being part of the service delivery team. This may hamper the extent to which complex needs of vulnerable groups can be met.

"For me it comes down to integrated social care, that's about everybody who does anything that has an impact on people's health and wellbeing should be involved. So, for me, the integrated joint order would involve public, private and third sector people of being able to work in that arena and all being paid fairly for it, and being trusted and respected as professionals. The reality is, it's not. It's the Council and the NHS, working with budgets and funnelling it into their own services and a lot of the time that's not, they are not the answer to whatever the problem is..."
(SL Third Sector E)

Acute and the independent sector were also described as not being integrated, which respondents suggested constrained integration. Although reducing pressures on hospitals was mentioned frequently as a goal of integration, respondents said Acute was not integrated with Primary Care or the community. The Lived Experience Panel reinforced the importance of integration between the two:

"We have to have more social care involved in hospitals because it's not just medical support that people need, it's also mental health support that they need in that moment that they're not getting. Every suicide is a tragedy because that's someone's child, that's someone's parent."
(Lived Experience A)

Very few respondents mentioned the independent sector and those who did said it was not a core part of the integration agenda. Although respondents in NL noted that roles had been established to represent the independent sector on both Health and Social Care Partnerships, the sector's role was described as more removed due to having different financial goals and a power imbalance through the commissioning model. However, respondents expressed the sector's importance in delivering care and in supporting goals around keeping people out of hospital, but at the same time, noted the lack of training and career progression opportunities for carers, as well as low pay.

> "... they get a 10 minute video on some things to get trained, and this is what I've heard from the horse's mouth, with some of the nurses, 'Like we only get a 10 minute video and then we're alright'. And this is from some of the private companies that hire out care."
> (Lived Experience B)

Respondents referred to a domino effect, with understaffing in home care resulting in poorer user experience and causing stress on other parts of the Health and Social Care system. Understaffing across Health and Social Care was also considered to negatively impact person-centredness:

> "... home support is not as good as it once was because we are so short staffed. In that way, if we're talking about home support, maintaining someone at home and maintaining their health, I would say absolutely that's got worse. And that's to do with the stresses and strains that are on home support, which then impacts on us because we then... The situation just goes into crisis. Do you know, people's mental health goes down. So community mental health team are more under pressure for that. District nurses because people's physical health will be deteriorating."
> (NL Social Work)

At the centre of the system, respondents suggested that the person/patient/service user would unite the various actors and reinforce the goal of person-centredness. This was linked to a need to change metrics for evaluating services, mentioned in section 5, and the locality-based approach aspired to under integration. However, this would require two things: that local strategic decision makers are fully versed and understand local needs, including the disparities between neighbourhoods; and that there is capacity in the system to contend with need, which would require investment.

> "... that's really what integrating is about, it's about making sure the person is at the heart of what it is, that you're doing, and the services you put in meet their needs. It's not about just referral all the time, that doesn't work."
> (SL Third Sector E)

> "So I understand a kind of seamless, well communicated assessment of people's health needs and what different partners can do to improve the health of that individual... It should be about holistic working... What it actually is just joined up governance. I think that's all it has achieved ... I'm not entirely sure that it works."
> (NL Third Sector B)

6.2 Constraints on a systems approach

In addition to the constraints of separate governance mechanisms and budgetary silos, which have already been mentioned in section 3, respondents discussed the various, individually complex, parts of the system (e.g. Acute, Primary Healthcare, Social Work, third sector) all of which are working under extreme pressure, which are exasperated by high levels of staff vacancies. Joining each of these up within an integrated system would be a colossal task, which would take considerable time and would require transformative change across different levels of the organisations. It would likely require clear strategic goals that unite the Health and Social Care system, which feed into the goals of the various actors within the system. This is particularly complex in Lanarkshire where two Health and Social Care Partnerships are in operation.

> "It's a huge it's a huge jigsaw that's just miles apart. All the pieces are miles apart. And they're moving further and further apart."
> (NL Social Work)

Various respondents said that the pace of change is very slow, especially given the need for transformative changes to the complex Health and Social Care system, which are embedded in cultures and long-standing power dynamics.

> "I think that's a cultural thing here. I think, you know, you've had NHS and you've had Council very much working in silos for, you know, for years. And I think it's been very difficult probably to bring them aligned with what an integration agenda looks and feels like... we might be coming at different places with aspects of this but we know what our common goal is. And I think they've found that commonality and I think you know the strategic commissioning plan underpins that commonality."
> (NL Third Sector C)

Furthermore, respondents mentioned specific constraints to adopting a whole systems approach, including different local needs and infrastructures, meaning a one-size-fits-all systems approach would not be appropriate. Considerable tension therefore exists between developing both a whole-system approach and a locality-based approach which

considers the needs and capacity of the local system.

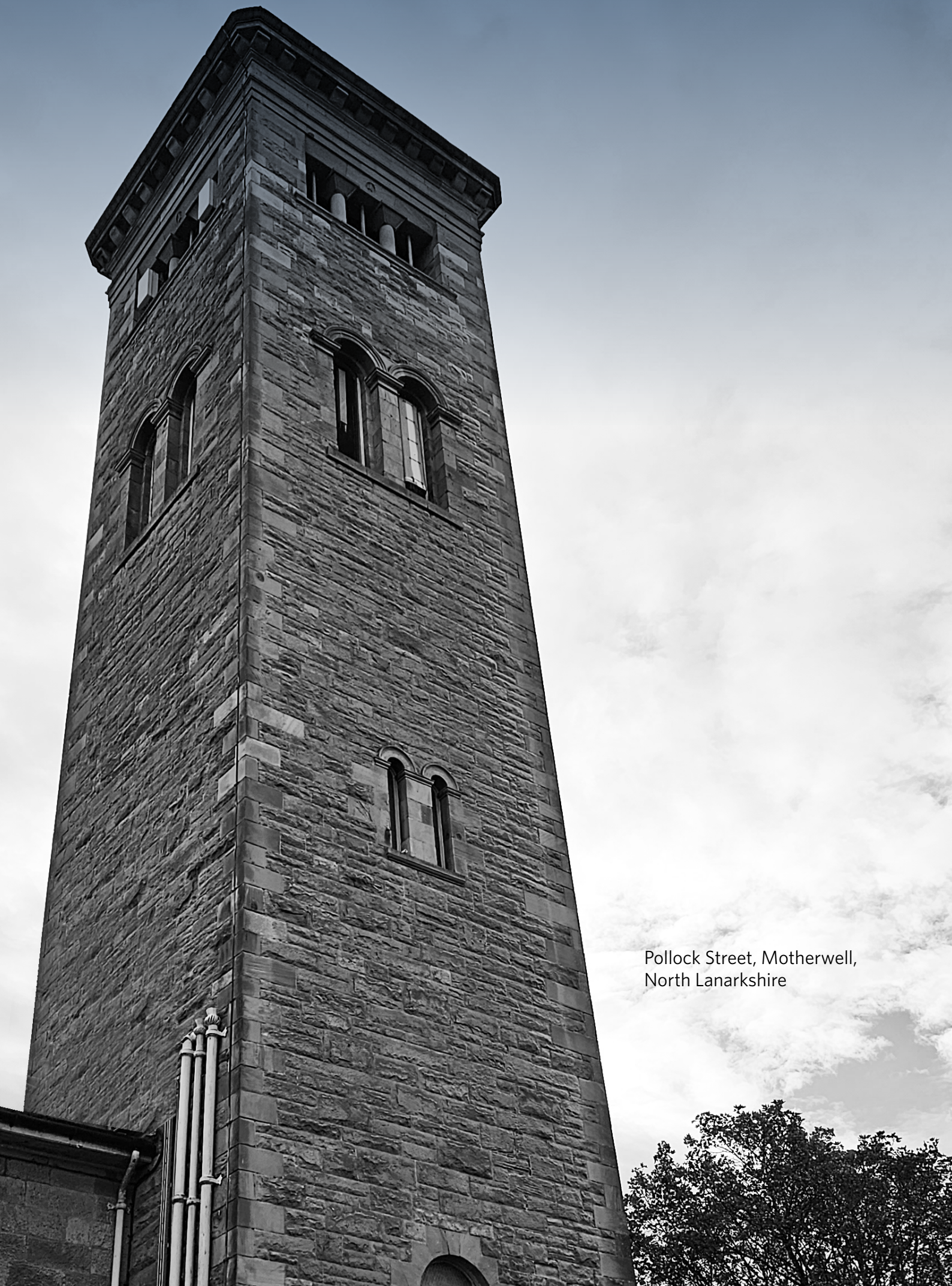
> **"... the nature of the way that the partnership is all set up... it's impossible to take a whole systems approach because, you know, the argument would be that the population of North Lanarkshire is not the same as the population in South Lanarkshire. And you would be right because if you look at areas of social deprivation and there is lots of evidence if you go and look at your health outcomes in certain areas they're hugely different."**
> **(Health C)**

7. Emerging Conclusions

The findings of this exploratory study highlight the complexities of the Health and Social Care landscape and some of the challenges in contending with health inequalities. Although the analysis offers some agreement that integration enables joint working, it suggests relationships between different sectors and organisations need to be further established, developed and embedded at both decision making and service delivery levels to support integration in practice and goals around person-centred care and efficiency. This is especially important in a context where increasingly complex demand on Health and Social Care services has been felt across the statutory and third sectors.

While this research suggests gaps in third sector engagement with Health and Social Care Partnerships during decision-making and service delivery, the role of various other actors (e.g. Independent Care Sector) was not captured in detail and should be considered in more depth in future research. The analysis also suggests that although integration has led to changes in ways of working, such as the establishment of MDTs, there is less evidence regarding its impact on service users, patients and communities. However, the findings indicate that integration is not enough to contend with the complexities of health inequalities and that, in practice, reducing inequalities is not prioritised in the practices of those delivering Health and Social Care services.

The analysis suggests the need to zoom out to understand the wider system of actors and relationships, the macro-level enablers and constraints impacting health, wellbeing and inequality, while also centring on the needs, resources and connections within local communities. To achieve a whole-system and locality-based approach, the analysis advocates for transformative change to connect disjointed parts of the system and to challenge persistent structural barriers, with four broad suggestions emerging from the analysis. First, firmly placing the person and the community as the focus of integration. With the person at the centre, planning and delivering services according to a holistic view of that individual and their needs is reinforced and helps to unite various professionals/organisations. Focusing on the community emphasises broader community needs and the capacity within the area to meet those needs. This would be reinforced by concentrating on longer-term outcomes and qualitative measurements rather than on processes and outputs. Second, changing or flexing rules to support sharing of knowledge, resources and skills across organisations and sectors; this would encourage understanding of roles and enable access to IT systems to share information. Third, re-allocating budgets to shift resources towards local need and early intervention services to minimise longer-term impact on other parts of the Health and Social Care system. Finally, developing alternative structures to engage more effectively with the third sector and communities in local decision-making and day-to-day service prevision. Embedding the role of the third sector, requires the development of working relationships at different levels of the system, and especially during local decision-making and service delivery.



Pollock Street, Motherwell,
North Lanarkshire

commonhealth
CATALYST

UKRI Arts and Humanities Research Council

CommonHealth Catalyst was funded by the Arts and Humanities Research Council (AHRC)

November 2022 to September 2023

CommonHealth Catalyst: Developing a community research consortium to address health disparities' was funded by AHRC's 'Mobilising community assets to tackle health inequalities' programme. Ref: AH/X005801/1

GCU Glasgow Caledonian University
University for the Common Good

Glasgow Centre for Population Health

NHS Lanarkshire

The Health & Wellness Hub

University of Glasgow

GCU Glasgow Caledonian University
University for the Common Good

Glasgow Caledonian University,
Cowcaddens Road, Glasgow G4 0BA,
Scotland, United Kingdom