



D5.1 Readiness of European Regions for Integrated Care

Annex H: Self-assessment process in Midlothian, Scotland

WP5 Maturity Assessment for Integrated Care



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1	Introduction	3
1.1	Characteristics of healthcare system	3
1.2	Integrated care in Midlothian, Scotland	6
2	Self-assessment process in Midlothian, Scotland	6
2.1	Identification process of the local stakeholders.....	6
2.2	Self-assessment survey	7
2.3	Stakeholder workshop	19
3	Analysis of the outcomes	24
4	Key messages	24
5	Conclusions and next steps	25
6	Annex 1 Self-Assessment Workshop in Scotland - Agenda	26

1 Introduction

Scotland is a country that is part of the United Kingdom, with a population of 5,4 mil inhabitants. It constitutes a distinct jurisdiction in both public and private law. In 1997, a Scottish Parliament was re-established, in the form of a devolved unicameral legislature, having authority over many areas of domestic policy, including healthcare policy. Scotland's healthcare policy is currently administered through the Health and Social Care Directorates of the Scottish Government.

Health and social care are devolved issues in the United Kingdom. Healthcare in Scotland is mainly provided by Scotland's public health service, NHS Scotland. It provides healthcare to all permanent residents free at the point of care and paid from general taxation. Private care is usually paid for through private healthcare insurance schemes or by individuals.

NHS Scotland is managed by the Scottish Government, which sets national objectives and priorities for the NHS. Of approximately £34.7 billion controlled by the Scottish Government, around £11.9 billion is spent on health. The provision of healthcare has been the responsibility of 14 geographical, local NHS Boards and 7 National Special Health Boards¹ which collectively employ approximately 160,000 staff.

1.1 Characteristics of healthcare system

Item	Description
Region	Midlothian Health and Social Care Partnership, Scotland
Geographical scale of the region	Regional
Geographical size and dispersion of the region (km ²)	354 km ²
Population size of the region (thousands)	91,000. Midlothian is the fifth smallest Scottish mainland council by population size and is the fastest growing by population according to 2026 estimates.
Population density of region (inhabitants/km ²)	Ranked 25th of the 32 Scottish Local Authority Areas. 258 per Km ²
Life expectancy of the region (years)	Life expectancy for women in Midlothian in 2017 was 81.6 years for women and 77.9 years for men. Life expectancy for those born in Scotland in 2016-2018 was 77.0 years for males and 81.1 years for females (National Records of Scotland).
Fertility rate of the region (births/woman)	The total fertility rate in Midlothian was 1.83 in 2018. In 2018, there were 1,075 births in Midlothian. The rate was 12.2 per 1,000 population in 2018. In comparison, the rate in Scotland overall decreased from 9.7 to 9.4.

¹ These include NHS Health Scotland, Healthcare Improvement Scotland, Scottish Ambulance Service, the Golden Jubilee National Hospital, the State Hospital, NHS24, NHS Education for Scotland and NHS National Services Scotland.

Item	Description
	In 2018, Midlothian was the council area with the joint highest standardised birth rate.
Mortality rate of the region (deaths/1,000 people)	In Midlothian, the standardised death rate was 10.3 in 2018.
Top three causes of death of the region	<p>In Midlothian, the leading causes of death for males in 2018 were: Ischaemic heart diseases (12.6% of all male deaths), followed by lung cancer (7.9%) then Dementia and Alzheimer Disease (7.6%).</p> <p>The leading causes of death for women were Dementia and Alzheimer Disease (16.2%), Ischaemic heart Diseases (11.4%) then Cerebrovascular disease (8.2%).</p>
Organisation and governance of healthcare services	<p>Following the 2016 legislation in Scotland for the Integration of Adult Health and Social Care, health and care services in Midlothian are jointly provided by NHS Lothian and Midlothian Council in the new structure called an Integrated Joint Board (IJB). As members of the IJB, the Council and Health Service each agree how much to allocate to the IJB, and it then decides on local priorities and instructs the Council and Health Service how to use this joint funding.</p> <p>Adult Care Social Care may be provided by the local authority (local government) or is purchased from the voluntary or independent sector providers (67%).</p> <p>Community health services may be provided by primary care and service providers e.g. General Practice, Community Nursing, Pharmacy, Mental Health Services etc.</p>
Healthcare spending of the region (% of GDP)	<p>The Midlothian Health and Social Care Partnership (HSCP) 's integrated budget for health and care in 2018/19 was £142m. The breakdown for health and social care was:</p> <ul style="list-style-type: none"> • Midlothian Council: £43m • NHS Lothian: £88m
Distribution of spending in the region	<p>The total spent by Midlothian Council (local authority) in 2018/19 was £200.9million. The majority of Midlothian Council's budget for services (76.5%) comes as grant funding from the Scottish Government.</p> <p>Council Tax (local tax paid by citizens) provides a quarter (23.5%) of the Council's budget for local services. The Council funds Education, Communities, Development and Health and Social Care (25%).</p> <p>Approximately one quarter (25%) of expenditure by Midlothian HSCP is on services for older people. In 2018/19, the spend on adult social care and older people was £39.8m</p>
Size of the workforce (thousands) and its distribution (%) in the region.	The population of Midlothian is 91,000. The working age population is 57,000. In 2018, there were 47,300 people economically active in Midlothian.

Item	Description
	<p>NHS Lothian has a workforce of approximately 27,000 people.</p> <p>The Midlothian HSCP has approximately 1100 full-time staff and 691 of these work in adult social care.</p> <p>484 staff work in NHS Lothian (Midlothian only).</p> <p>In addition, there are 1400 part-time staff.</p> <p>Midlothian HSCP has contracts with 40 voluntary sector organisations - their staff numbers are not included here.</p> <p>Detailed figures for staff roles is difficult to obtain, however, according to the 2019 Joint Needs Assessment, there are 12 G.P. practices in Midlothian, with a compliment of 80 GPs and 41 nursing staff.</p> <p>Allied Health Professionals (AHPs) work in health and care settings (including patients' homes, hospitals, community-based teams and surgeries) alongside doctors, dentists and nurses. The HSCP directly employs Occupational Therapists (OTs) (in the Council and NHS) as well as Physiotherapists in the NHS.</p> <p>A total of 60 whole time equivalent OTs and Physios are employed across health and social care.</p> <p>Other Allied Health Professionals (AHPs) - Podiatrists, Speech and Language Therapists, Arts Therapists, Radiographers and Dietitians - work across NHS Lothian NHS services which includes providing care to Midlothian residents.</p> <p>Arts Therapy and Dietetics are hosted in Midlothian. The service employs 100 whole time equivalent Dietetic staff and 7 Arts Therapy staff who work all across NHS Lothian.</p>
Healthcare policies in the region	<p>Cancer - National/Local Guidance:</p> <p>Beating Cancer: Ambition and Action (2016)</p> <p>National Health and Care Delivery Plan (2017-18)</p> <p>Better Cancer Outcomes in Lothian - A Strategy for Cancer (2014 - 2020)</p> <p>Respiratory Disease: COPD & Asthma</p> <p>National/Local Guidance:</p> <p>NICE Guidance</p> <p>British Thoracic Society: Guidelines (Asthma & COPD)</p> <p>NHS Lothian: Guidelines</p> <p>Scottish Government: COPD best practice guide</p> <p>Social Care Support</p> <p>National/Local Guidance:</p> <p>Realistic Medicine</p>

Item	Description
	Self-Directed Support Fair Access to Care

1.2 Integrated care in Midlothian, Scotland

In April 2016, The Public Bodies (Joint Working) (Scotland) Act 2014 came into force and Scotland's healthcare system became an integrated service under the management of Health and Social Care Partnerships (HSCPs). The Act is the legislative framework for the integration of health and social care services which requires the integration of the governance, planning and resourcing of adult social care services, adult primary care and community health services and some hospital services. Other areas such as children's health and social care services, and criminal justice social work can also be integrated. The Act signified new joint working arrangements between Local Authorities and NHS Boards to improve the co-ordination of health and social care in Scotland. As a result, local authority nominees, responsible for the provision of social care, were added to the Health Boards' membership to improve the coordination of health and social care. As a result, there are 31 HSCPs that are jointly responsible for the commissioning and delivery of social care, community health, primary care and some hospital services. Midlothian HSCP is one of these Partnerships². The aim of this Act was to enable better coordinated, joined-up and more continuous care, resulting in improved patient experience whilst achieving greater efficiency and value from health and social care delivery systems. There was a recognition of the need to move towards a more integrated, person-centred approach that is designed for citizens in a way that co-ordinates services around their needs and puts them in control, thus enabling them to participate in, and make informed decisions about, their care. The mainstreamed adoption of technological solutions within service redesign was perceived as a major facilitator of such a change.

2 Self-assessment process in Midlothian, Scotland

2.1 Identification of local stakeholders

The local stakeholders were identified with the support of the Midlothian HSCP. A multi-disciplinary and multi-level group of experts in health and social care integration was selected to assess the maturity of the Partnership for the adoption of integrated care. The main rationale was to capture the perceptions of stakeholders at three distinct levels:

- governance,
- strategic/planning;
- operational.

² <https://www.legislation.gov.uk/asp/2014/9/contents/enacted>

The profiles of the local stakeholders are provided in the table below:

Table 2: Stakeholders' profile

Position	Group
Chief Officer	Integration Joint Board/Strategic Planning Group & Joint Management Team
Head of Services - social work and adult services	Strategic Planning Group
Elected Member	Integration Joint Board
Community Representative	Integration Joint Board
Service User Representative	Strategic Planning Group
Strategic Planning Lead	Strategic Planning Group
Lead Physiotherapist	Joint Management Team
Union Representative Member	Strategic Planning Group
Strategic Planning Lead - Acute Hospitals	Strategic Planning Group
Public Health Consultant	Strategic Planning Group
Lead Occupational Therapist	Joint Management Team
Service Manager - Disability	Joint Management Team
Programme Manager - mental health/COPD	Joint Management Team
Service Manager - Community Justice	Joint Management Team
Operational Lead - Intermediary care	Joint Management Team
Technology Enabled Care Strategic Lead	Strategic Planning Group
Elected Member	Integration Joint Board
Integration Manager	Joint Management Team
Integration Manager	Joint Management Team
Chief Nurse	Integration Joint Board & Strategic Planning Group
Lead Pharmacist	Joint Management Team

2.2 Self-assessment survey

In order to capture stakeholders' individual perceptions and opinions on the maturity level of the Midlothian HSCP in integrated care, **22 stakeholders were invited to participate** and they all accepted the invitation. The self-assessment process was carried out between December 2019 and January 2020.

Stakeholders were invited to:

- Register on the SCIROCCO Tool's web page
- Perform the individual self-assessment
- Share their self-assessment outcomes with the HSCP's local coordinator.

In this regard, the local coordinator provided the following information to stakeholders:

- Background information to the SCIROCCO Exchange project, its objectives and potential added-value for the HSCP;
- Information on the organisation of the maturity assessment process in Midlothian and next steps.

All stakeholders filled the online survey at the beginning of January 2020.

2.2.1 Outcomes of self-assessment survey

13 stakeholders filled the online self-assessment survey, including the provision of their justifications for their ratings. The following spider diagrams reflect the diversity of the stakeholders' perceptions on the maturity of integrated care in the Midlothian HSCP. It is very insightful to observe the differences in perceptions, not only among the three different levels of stakeholders, but also within these groups themselves.

Figure 1- Outcomes of the individual self-assessments - Perceptions of Integration Joint Boards

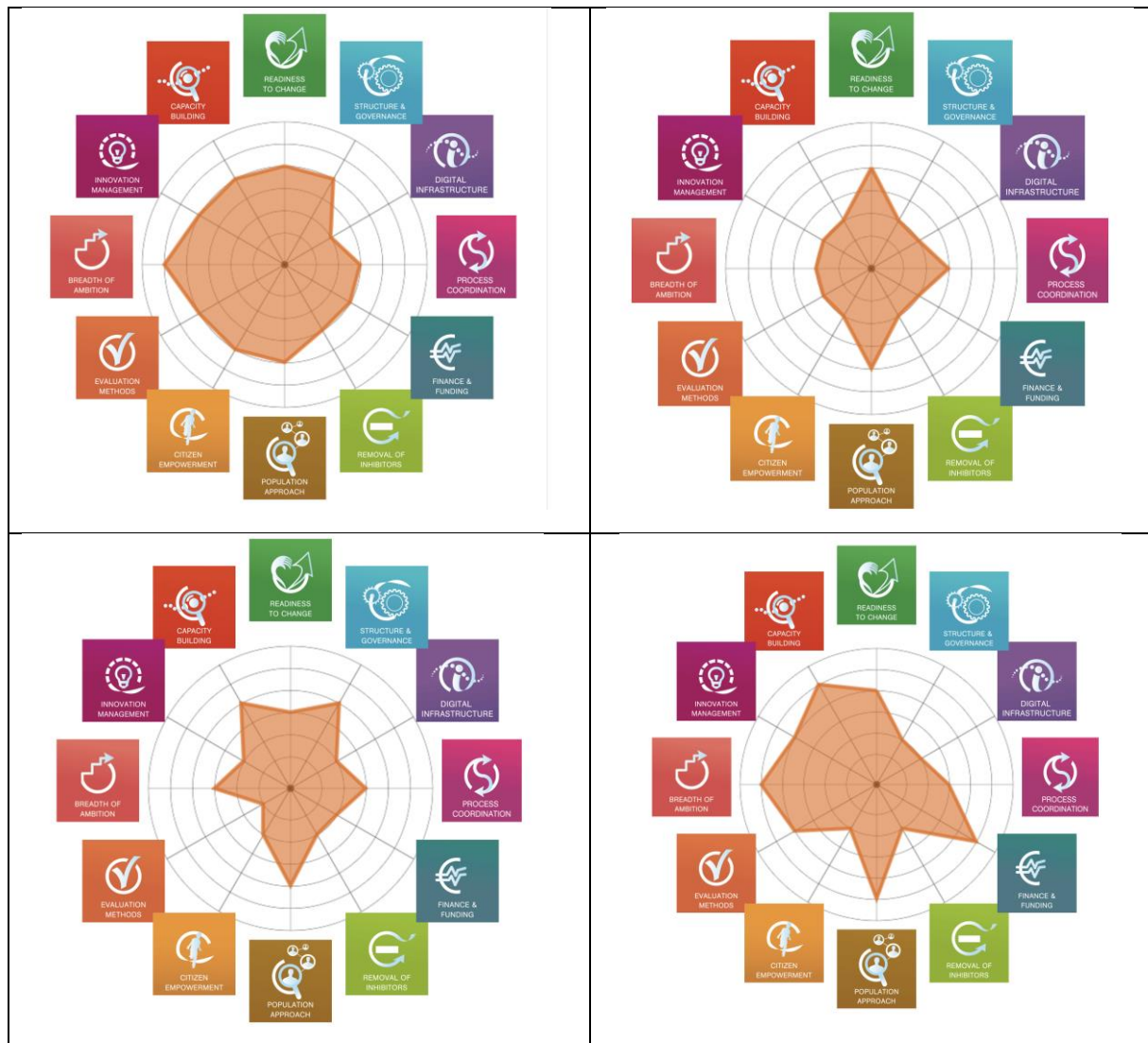


Figure 2 - Composite diagram - Diversity of perceptions of the members of the Joint Board



As the outcomes of the individual assessments in the Joint Integration Board group indicate (Figure 2), there is a disparity in members' perceptions of the level of maturity of integrated care in Midlothian's HSCP. We can observe that agreement was reached in only two domains of the SCIROCCO Exchange tool: **"Digital Infrastructure"** and **"Process Coordination"**, for which a maturity level 2 was agreed for both.

All stakeholders tended to agree that there was a strong recognition of the need for more joined up and integrated digital infrastructure but that IT systems still remained separate at all levels of health and social care delivery. Also, services were not digitally integrated from the users' perspective. However, although there were some good examples already in place, the approach was not systematic.

With regard to "Process Coordination", respondents acknowledged that some standardised, co-ordinated care processes were underway, particularly when in relation to new services, but this was not the case for existing routine services. A more systematic approach is planned and more work still needs to be done to increase the maturity of this dimension.

A relatively good level of agreement was also reached on the following dimensions:

- **“Readiness to Change”** - Stakeholders tended to agree that there was a vision and plan for transformation towards integrated care embedded in policy, supported by strong leaders and champions. This was reflected in a relatively high average level of maturity (3). However, they acknowledged that there was a lack of awareness by some staff and that this might be due to a number of reasons; e.g. position in the organisation. Also, more work needs to be done on public awareness as citizens are unlikely to have the same level of understanding of the need for change.
- **“Removal of Inhibitors”** - Stakeholders tended to agree that there was a great level of awareness of the need to remove inhibitors and some plans and strategies are in place. However, this domain scored relatively low (a maturity level of 1-2) as there was still some silo thinking despite all the hard work internally within the Partnership. There is no systematic planning on the removal of inhibitors, but the overall situation has improved.
- **“Population Approach”** - Stakeholders agreed quite a high level of maturity for this dimension (3-4) which is reflected by the existence of a number of good solutions based on risk stratification and also by the fact that this is an agenda that can be supported and influenced locally. There is also a need to focus on what to do with the results of stratification.
- **“Innovation Management”** - the scoring of this dimension reached either the level of maturity of 1 or 3. With regard to the maturity level of 2, the main perception was that, although the Midlothian HSCP is very forward looking and stakeholders explore outside their own areas, generally across Scotland there is a lack of sharing of good practices. In contrast, those ranking this dimension as 3 acknowledged that there was a strategic plan and political commitment to innovation, also supported financially, which is a crucial factor for more formalised innovation management.
- **“Structure and Governance”** - A similar situation was observed in this dimension. Stakeholders tended to rank either a maturity of 1 or 3. For those scoring the level 1, the main issues were: existing fragmentation of governance in the Partnerships (some are members of both groups (as outlined in the Table 2) which sometimes creates conflicting pressures); and lack of long-term funding which means that the planning is limited. As a result, systems and processes are still separated. In contrast, those ranking this dimension as 3 acknowledged that new governance structures to support the integration of health and social care services are in place so the roadmap for change has been partially implemented. However, it was also highlighted that the current governance arrangements could have been simplified. There is governance at a national level but the situation at a local level is too complex to achieve a higher maturity scoring.

The dimensions with the highest level of disparities of scoring were:

- **“Funding”** - Ranking in this dimension varied from 1-4 levels of maturity. One of the arguments for low scoring was the fact that the funding is diverse and short-term which limits the funding of any extra transformation or scaling-up initiatives. The

situation is even worse when it comes to social care. In contrast, there was also a perception that funding for ongoing operations is available and decisions are done locally about where the funding is allocated.

- **“Citizen Empowerment”**- Ranking on this dimension varied between 1-3 even though the majority of stakeholders tended to agree that the level of maturity should be 1 for a number of reasons; despite all the good practices in the Partnership, citizen empowerment is still not fully embedded, and it lacks consistency. There was also a feeling that public engagement needed to be improved. In contrast, other stakeholders argued that there is a strong commitment in Midlothian HSCP to citizen empowerment and citizens are consulted on their health and social care services and have access to their data. However, it was also acknowledged that more work is needed to improve the situation.
- **“Evaluation Methods”** - Ranking on this dimension also varied between 1 to 3 level of maturity. One of the low scoring perceptions was that we tend to evaluate the effectiveness of services rather than the degree of integration or how things come together holistically. The goals and targets for evaluation need to be better defined. In contrast, it was argued that in case of new services, evaluation is systematic and embedded as part of system redesign which is a great improvement.
- **“Breadth of Ambition”**- Ranking on this dimension varied between 1 to 4 level of maturity. The arguments for lower scoring were the fact that even though we have elements of all levels of this dimension in place, but it is not consistent. In contrast, it was argued that there are policies, systems and process in place to support the ambition of full health and social care integration. The ambition is set quite high, both at national and local level.

Figure 3- Outcomes of the individual self-assessments - Perceptions of Strategic Planning Group



D5.1 Annex H - Self-assessment process in Midlothian, Scotland

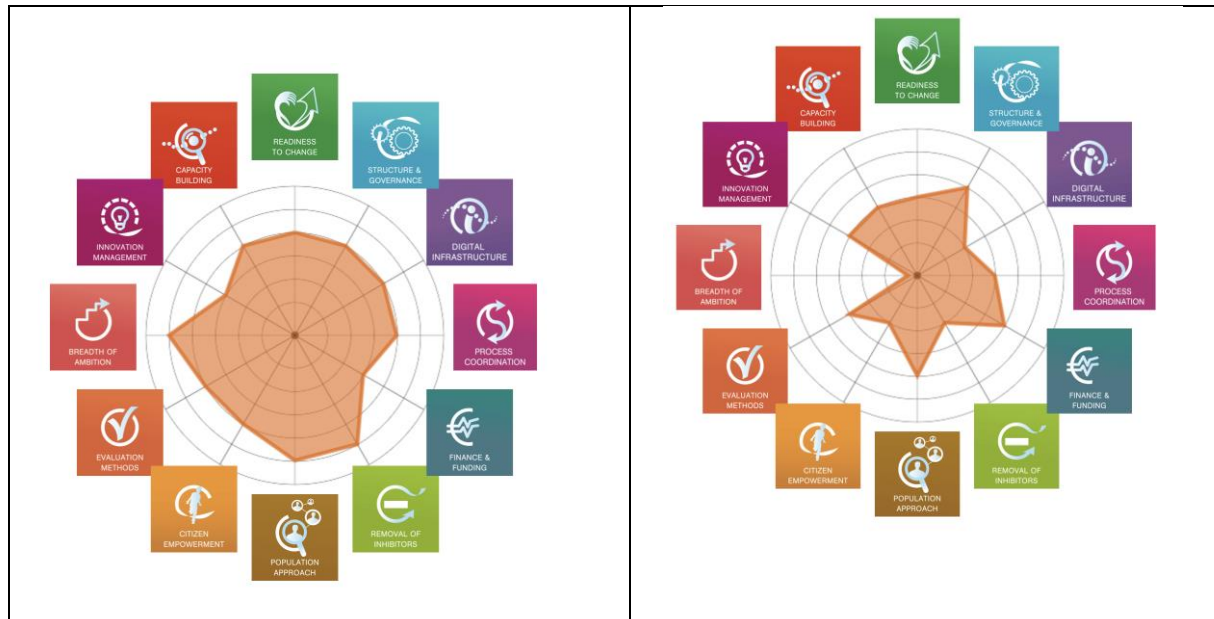


Figure 4 Composite diagram - Diversity of perceptions of the members of the Strategic Planning Group



As the outcomes of the individual assessments in the Strategic Planning' Group indicate (Figure 4), there was a disparity in members' perceptions of the level of maturity of integrated care in Midlothian HSCP. It is interesting, however, that we can observe much more coherent scoring, with only slight variances across a number of dimensions compared to members of the Joint Integration Board. However, there was no single dimension where all stakeholders assessed the same level of maturity.

A good level of agreement was reached in a number of dimensions:

- **“Readiness to Change”** - Ranking in this dimension varied between the maturity of 2 and 3. Stakeholders clearly agreed that the need to change was acknowledged widely by the Midlothian HSCP which is reflected in a number of plans and strategies in place. These are also supported by strong monitoring and reporting on the outcomes. There are already some good examples of change however there is still a lack of coherent and consistent approach adopting new models of care. Also, there is complexity of the relationship between the acute and primary care sectors which seems to be a barrier to faster progress. In addition, the needs of social care needs to get a higher profile, as the current system is still dominated by medical models of care. Public consensus is still very difficult to measure in order to score higher in this dimension.
- **“Structure and Governance”** - Ranking in this dimension varied between the maturity of 2 and 3, with a majority of stakeholders voting for maturity level 3. There was a high level of agreement that there is an ongoing internal restructuring that will see the establishment of appropriate governance to address the national ambitions for integrated care. This new governance framework is supported by a change management plan, however the real implementation still remains a challenge and there is a need to continue building relationships among the new entities. Stakeholders reflected that the structure at a local level could have been simplified.
- **“Process Coordination”** - Ranking on this dimension varied between the maturity of 2 and 3. There was an agreement that the services, pathways and care processes are getting formally described in a standardised way and some improvements can be observed. However, progress in this area is rather complicated because the acute part of the healthcare system that Midlothian HCSP works with also operates across other Integration Joint Board areas. There is a dichotomy between the ambition to provide services that meet local needs and the benefits of standardising to some extent on a regional/Midlothian basis. In general, one can conclude that establishment of a reliable process varies by team/services. Whilst there are well defined pathways in health and care respectively, at some interfaces (particularly care requests and allocation) the bridge is still variable.
- **“Funding”** - Ranking on this dimension varied between 1, 2 and 3, with a majority of stakeholders voting for maturity level 2. It was acknowledged by stakeholders that there is a diversity of funding available, but it is not enough to achieve scaling-up ambitions. In contrast, most of the discussion about integrated planning and financing was about budget reductions which inhibits the development of services.

- **“Population Approach”** - Ranking on this dimension varied between 3 and 4, with a majority of stakeholders voting for the maturity level 3. The main arguments acknowledged all the work that has been undertaken to understand the population of Midlothian and the risks within the population, with a view to guiding the solutions that are put forward. This can be seen as a core focus of Midlothian’s strategy. However, most of the available data still has a health bias.
- **“Citizen empowerment”** - Ranking on this dimension varied between 1 and 3, with a majority of stakeholders voting for the maturity level of 3. It was acknowledged that the citizens of Midlothian were consulted in the development of the Strategic Plan and Midlothian HCSP continues to reach out to citizens for feedback on services. There is a strong commitment to citizen empowerment but this lacks a systematic approach. It is also very difficult to ensure the consistent involvement of all citizens.
- **“Evaluation methods”** - Ranking on this dimension varied between 2, 3 and 4, with a majority of stakeholders voting for the maturity level of 3. It was perceived by local stakeholders that some services are being measured and assessed (based on objective metrics) but this is not consistent. There is a recognition that there is a value in taking a more systematic approach to evaluation through the Strategic Planning Group. In general, more qualitative data is required.
- **“Innovation Management”** - Ranking on this dimension varied between 2 and 3, with a majority of stakeholders voting for the maturity level of 2. Innovation is very much recognised across Midlothian HCSP which is also reflected in the local strategy, however further involvement of social care staff should be encouraged. There are already some good practices in place and innovation is mostly seen as the key driver for achieving long-term financial sustainability as well as the objectives of the realistic medicine. Further improvement is perceived when it comes to the capturing of innovation and supporting more efficient knowledge transfer.
- **Capacity-building** - Ranking on this dimension varied between 2 and 3, with an equal distribution of scorings. Stakeholders agreed that cooperation on capacity-building is growing across the Partnership, the journey has started but more work is needed to improve on this dimension. It is a consistent problem of how to build capacity and resilience in the constant cycle of change management and, at the same time, maintain the day-to-day operation of services. In general, there is definitely an ambition to share knowledge and experience in Midlothian.

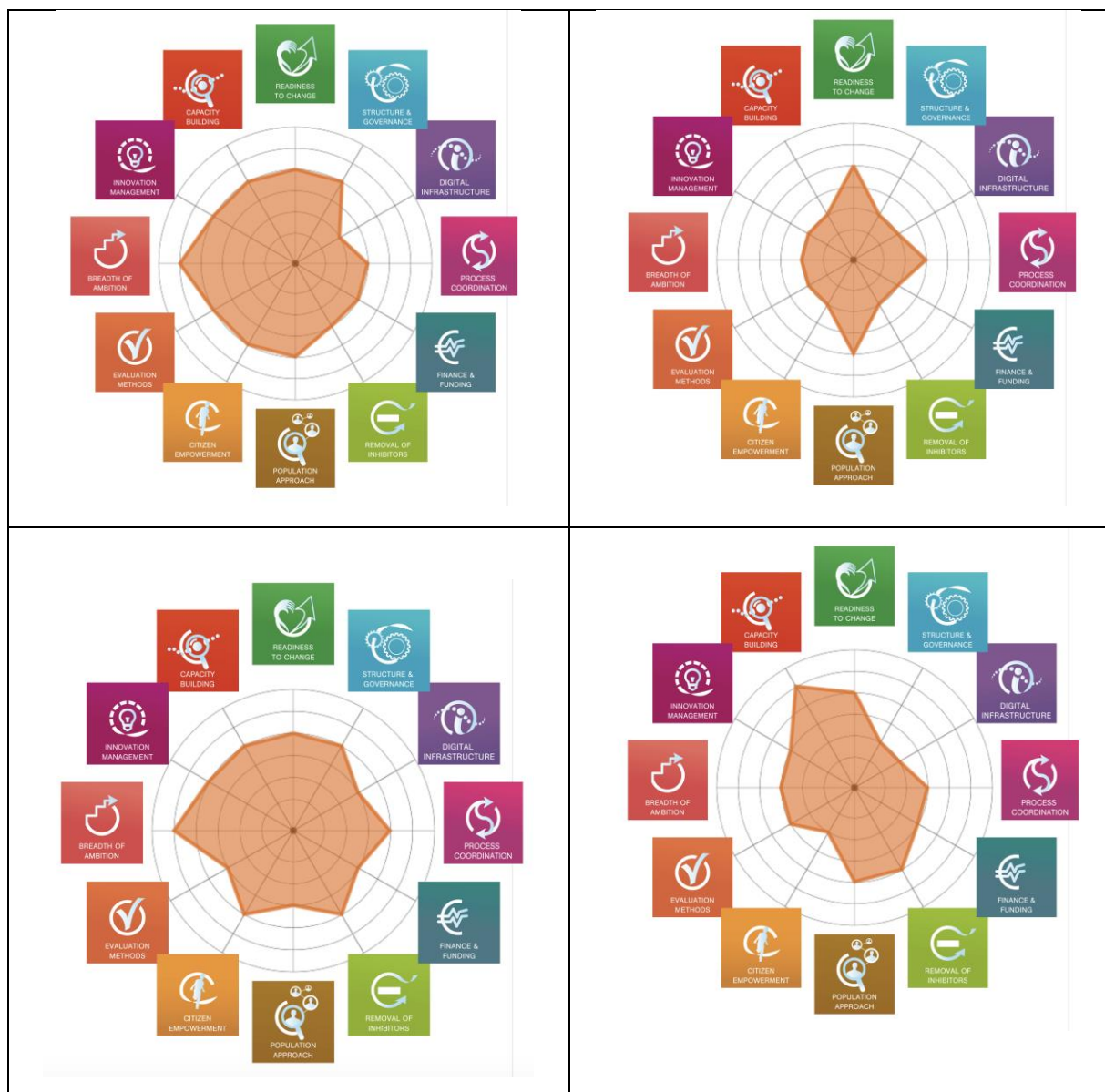
The dimensions with the highest level of disparities were:

- **“Digital infrastructure”** - Ranking on this dimension interestingly varied from 1-4 level of maturity. One of the arguments for low scoring was the fact that, whilst means of sharing data do exist, this is far below the level of connectivity required to deliver an integrated digital infrastructure. IT provision is still NHS or Council, formal exchange tools (beyond web forms/email) are inoperative locally, basic administrative organisation calendars is lacking as well as no shared Wi-Fi. There are a number of good practices, but overall IT systems are not interconnected.
- **“Removal of Inhibitors”** - Ranking on this dimension varied between 1 and 4. The main argument for the lowest scoring was that inhibitors are dealt with on a project basis

and there is no systematic approach to removal of inhibitors. In contrast, there were views that Midlothian worked really hard on removing the inhibitors, particularly when it comes to information governance.

- **“Breadth of Ambition”**- Ranking on this dimension varied between 1 and 4 as well. The main argument for the lowest scoring was that even though the HSCP is integrated legislatively, it is lacking operational integration. In contrast, it was argued that ambitions for integrated care are set very high also at the local level. There are attempts to engage both horizontal and vertical stakeholders in planning and measuring services.

Figure 5 - Outcomes of the individual self-assessments - Joint Management Team



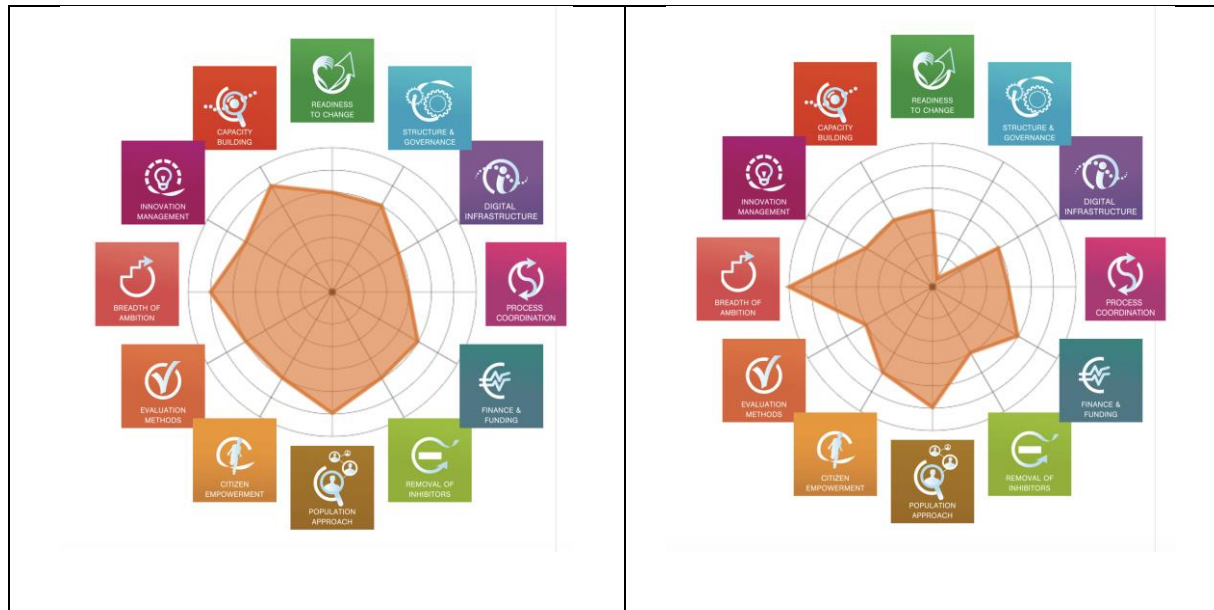
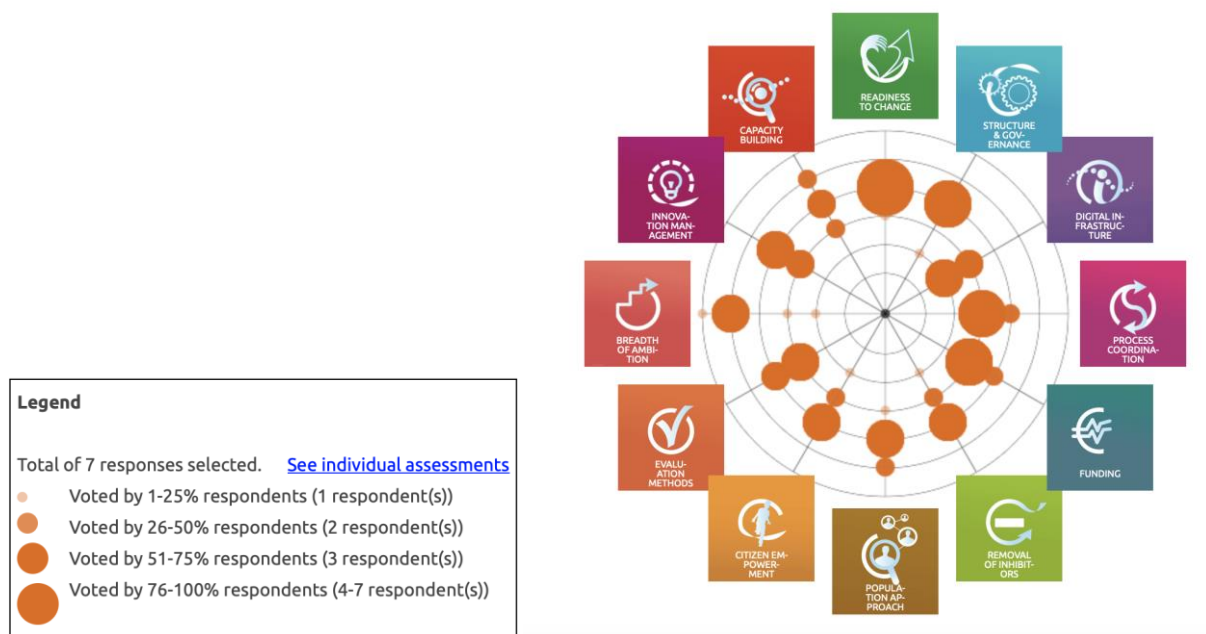


Figure 6 - Composite diagram - Diversity of perceptions of the members of the Joint Management Team



As the outcomes of the individual assessments in the Joint Management Team' group indicate (Figure 6), there is a disparity in members' perceptions of the level of maturity of integrated care in Midlothian's HSCP. It is interesting that we can observe much more diverse scoring, with only slight variances across a number of dimensions, compared to members of the Joint Integration Board or Strategic Planning Group. However, there was no single dimension where all stakeholders gave the same level of maturity.

A very good level of agreement was reached in a number of dimensions:

- **“Readiness to Change”** - Ranking on this dimension varied between the maturity of 2 and 3, with a clear majority of stakeholders voting 3. Stakeholders strongly agreed that there is a clear internal vision and plans but the need to change is not communicated to the wider public. Roles and responsibilities are clearly aligned to these visions and plans, including joint management arrangements and stronger links with other key agencies and systems which are vital to the prevention agenda, e.g. community planning, leisure and sport. Leaders are emerging with a strong passion and commitment for change, but it is not clear how it will be delivered operationally.
- **“Structure and Governance”** - Ranking on this dimension varied between the maturity of 1, 2 and 3, with a clear majority of stakeholders voting 3. Stakeholders acknowledged that, within the Midlothian Partnership, there is a clear structure and routes of governance are in place. However, the overall programme for change is still missing, although there are some individual change plans in specific areas. There is a need for ongoing review of structures and governance to reflect the actual needs in integrated care delivery. Some frameworks have been developed to ensure a consistent approach in Midlothian. The rationale for the lower maturity scoring was the fact that some technical difficulties prevent smooth governance changes.
- **“Digital Infrastructure”** - Ranking on this dimension was relatively low and varied between the maturity of 1 and 2, with a majority of stakeholders voting 1. The main arguments included: separation of IT systems for health and social care despite the existence of a few good practice examples; dependency on national solutions; need for cultural shift both within the workforce and in general public; lack of strategy on integrating health and social care systems.
- **“Process Coordination”** - Ranking on this dimension varied between the maturity of 2 and 3, with a majority of stakeholders voting 2. It was agreed that the work has started on better coordination of the processes and services but there is no systematic approach, this is mostly the case for new services, so it is not universal. Processes, in general, vary in different areas and across the services. It is very difficult to ensure that care pathways are in place when the Partnership is at the beginning of the journey.
- **“Funding”** - Ranking on this dimension varied between the maturity of 2 and 3, with a majority of stakeholders voting 2. They argued that some funding is available but, overall, funding constraints have a limiting effect. The Partnership is making maximum use of available transformation funding, however double running is major challenge and undoubtedly slows up the capacity for change. There remains the responsibility of responding to individual needs whilst seeking to invest in long term prevention and early intervention strategies. There is lack of recurring funding. A lack of experience and awareness of different funding is also an issue.
- **“Evaluation Methods”** - Ranking on this dimension varied between 2 and 3, with the majority of stakeholders voting 2. The main rationale was that there is lack of systematic evaluation and much evaluation tends to be the single system. Whilst Performance Management is becoming a stronger component of Midlothian’s Health

and Social Care Partnership, the toolkit to use evaluation methods is more ad hoc. There are, however, good and emerging examples including the local Wellbeing Service and involvement in national programmes including dementia and cancer.

- **“Innovation Management”** - Ranking on this dimension varied between the maturity of 2 and 3, with a majority of stakeholders voting 2. They argued that there are some innovation processes in place but these processes are not formally implemented and knowledge transfer between different areas of work is limited. The innovation is captured in a number of reports but not systematically. However, there are some good evolving examples - e.g. quarterly summits with the voluntary sector; telehealthcare programme; strategic planning at all levels of care; and transformation being the main driver for achieving long-term financial sustainability as well as the objectives of Realistic Medicine. In general, innovation is encouraged across the Partnership, however, it is very difficult to ensure systematic and formalised innovation management as the projects are so diverse and workload is large.

The dimensions with the highest level of disparities were the following:

- **“Removal of Inhibitors”** - Ranking on this dimension interestingly varied from 1, 2 and 3 levels of maturity. One of the arguments for low scoring was the fact that there are still two separate systems and processes for the health and social care system and there are no obvious moves at government level to rectify this. It is also very difficult to make changes at the ground level. Also, one needs to consider that some inhibitors are easier to remove than others and not everything is achievable in a short term. A systematic approach to remove inhibitors is missing. On the other hand, the main rationale for higher scoring was that inhibitors have been identified and have been removed despite all the difficulties. The Health and Social Care Partnership is fairly well integrated with clear established lines of communication. Many of the barriers can be simply overcome by communicating with your co-workers.
- **“Population Approach”** - Ranking on this dimension varied from 2,3 and 4 levels of maturity, even though most of the stakeholders tend to agree on the level of maturity level 3. The main rationale for the scoring 3 was the existence of a number of good practice solutions being used for some specific service users’ groups, but there are still a number of areas where there is no risk stratification, however work is being progressed. There is a feeling that this is an agenda that can be supported and influenced locally. In contrast, some stakeholders still perceive that the risk stratification approach is used in certain projects and on experimental basis hence they scored this dimension much lower.
- **“Citizen Empowerment”** - Ranking on this dimension varied between 1, 2 and 3 levels of maturity, with a majority of stakeholders voting for level 3. These stakeholders acknowledged that there is a strong commitment to citizen empowerment, including number of good practices but the systematic approach is lacking. Locally, there is a good sense on this agenda, but implementation remains a challenge. Public is consulted on service change implementation as a matter of course. Also, public views on how the Partnership provides its services are regularly asked for. The principle of

user involvement is well embedded in the organisation. Co-creation takes place in some areas but not methodically across services. However, there is still a tendency to ask people what they think of well thought out proposals rather than involving people from the outset. The biggest limitation of the citizen empowerment is lack of accessing the healthcare data.

- **“Breadth of Ambition”** - The ranking on this dimension varied between 1, 2, 4 and 5 levels of maturity with most of stakeholders voting for the maturity scale 4 and 5. The main rationale is the recognition that Scotland’s, as well as Midlothian’s, ambition in the agenda of integrated care is set quite high. There is already improved co-ordination between health and social care, however there are gaps in integration between care at different levels. In contrast, some stakeholders perceived that there is still a long way to go to manage to integrate primary and secondary care despite the existence of some of the good practices. At present, it seems that integration at primary care level is easier to achieve.
- **“Capacity-building”** - The ranking on this dimension varied between 2, 3 and 4 levels of maturity with quite dispersed perceptions between stakeholders. The higher scoring reflected Midlothian as a place where change is encouraged, always looking for new and more effective and efficient ways to run and manage the services. It is a relatively small sized Partnership which allows sharing of knowledge and spread of innovation across the whole area. There is a strong commitment to capacity-building which is evident through the retention of Midlothian’s own Learning and Development Service which is increasingly adopting an integrated approach. There has been significant investment in Organisational Development over a number of years although a dedicated resource is no longer available. Evidence through measures such as lower staff turnover is complex and not yet in place. Others argued that there is some acknowledgement of the need to build capacity to improve and develop services, but the acknowledgment of the scale of capacity that needs to be developed is limited.

2.3 Stakeholder workshop

The consensus workshop was organised by Midlothian Health and Social Care Partnership and facilitated by the International Engagement Team of the Scottish Government on 14 January 2020. The objective of the workshop was to discuss the preliminary findings of the self-assessment survey in the Partnership and to seek a multi-stakeholder understanding of the maturity of health and social care system for integrated care in Midlothian. The outcomes of the self-assessment surveys served as the basis for the multi-stakeholder discussion, negotiation and consensus-building.

2.3.1 Negotiation and consensus building

17 stakeholders participated in the face-to-face meeting with the ultimate objective of reaching a consensus across all 12 dimensions of SCIROCCO tool to achieve a final spider diagram, capturing the maturity of integrated care in the Midlothian Health and Social Care Partnership. The discussion was facilitated by the International Engagement Team of the Scottish Government. Each dimension was presented in terms of its objectives and

assessment scales, followed by introducing the different levels of maturity perceived by stakeholders. The main similarities and differences were highlighted and stakeholders were invited to reflect on these variations. As illustrated in Figure 7 below, stakeholders tended to agree the level of maturity for the following dimensions: Readiness to Change and Process Coordination. In contrast, the major discrepancies were found in the dimensions of: Evaluation Methods, Breadth of Ambition and Capacity-building. Ultimately, stakeholders were asked to provide the final scoring. In case there was no agreement on the final score of a dimension, the scoring with the majority of the votes was chosen. However, in general, the negotiation process was straightforward.

Figure 7 - Composite Diagram for Midlothian HSCP - Diversity of perceptions of all stakeholders



2.3.2 Final consensus

The outcomes of the consensus-building workshop are captured in the spider diagram and Table below:

Figure 8 - Final Consensus Diagram for Midlothian HSCP

Legend

Total of 12 responses selected. [See individual assessments](#)

- Voted by 1-25% respondents (1-3 respondent(s))
- Voted by 26-50% respondents (4-6 respondent(s))
- Voted by 51-75% respondents (7-9 respondent(s))
- Voted by 76-100% respondents (10-12 respondent(s))



Dimension	Scoring	Justifications & Reflections
Readiness to Change	3	There are plans and strategies to drive the agenda of integrated care in place and embedded in policy, mostly at national level. However, there is still a lack of awareness of wider public of the vision for a change and its rationale. It should be also noted though that this lack of awareness is also internal within the organisation which might be due to a position/role in the organisation. Senior teams are strong champions of the vision and need for a change and there is relatively good buying of all stakeholders involved.
Structure & Governance	2	The vision for change and integrated care is embedded very well at national level and this is followed by the structure at local level. However, there is a lack of action plans /operational guidelines on how to bring this vision into reality. Acute and community sectors are still working pretty much separately so there is no governance as such. Very often the new structures put some roles/positions in the organisation in the conflicting role e.g. dual memberships in the Boards. The structure seems to be more political than operational. Also, sometimes there is a feeling that the structure is in place, but it is not used effectively mostly due to the complexity of decision-making.
Digital Infrastructure	1	There is no single IT system for health and council staff which makes the digital infrastructure quite complex and fragmented. There are some good examples of work, particularly when it comes to the TEC Programme initiatives, but the system is not integrated from users\' point of view. In general, from a governance perspective, there are multiple information systems in place that often do not meet the requirements of the users. In addition, often digital care solutions are not embedded as part of service redesign and they are implemented mostly on adhoc basis. Digital infrastructure should be designed to reach the outcomes agreed, not the other way around. There are some good examples but there is no wide scale implementation of digital services. In some cases, basic problems such as connectivity and poor broadband connections pose the major barrier. Support services for the use of existing infrastructure need to improve as well, they are lacking awareness of what is needed to deliver truly integrated care services. However, there is strong commitment, and leadership buy-in, for the need for digital services. Technical standards are missing to facilitate data exchange, accompanied by a lack of trust in sharing health data. There is a need for national solutions and long-term investment otherwise it feels like "we have been there before" and no change is happening on the ground. From a social care point of view, the digital infrastructure is perceived as much more integrated.
Process Coordination	2	Some standardised coordinated processes are in place and guidelines are being used, particularly when it comes to new services, but no systematic approach is planned.
Funding	2	There is a diversity of funding coming to the Partnership from the Council and NHS but there is not enough funding for scaling-up and transformation of services, most of money is

Dimension	Scoring	Justifications & Reflections
		used for the core services. The funding is also mostly short-term.
Removal of inhibitors	1	There is a great awareness of existing inhibitors, but there is no real strategic approach/operational plan in place detailing how to remove these inhibitors systematically. There is still a lot of silo thinking within the organisation (e.g. how particular changes will affect my people). However, situation is much better if one looks at concrete local projects and teams.
Population Approach	3	Risk stratification is used for specific groups, but a population-based approach is not widely implemented yet. This is the only dimension which stakeholders felt they could directly influence.
Citizen Empowerment	2	Citizen empowerment is widely recognised as a key component of integrated care policies and strategies in Midlothian but there is lack of systematic approach. Citizens want to have better services but sometimes it is difficult for them to articulate how these services should look like. The language remains a key driver or rather obstacle of citizen engagement and further empowerment. There are pockets of good practices but not at wider scale.
Evaluation Methods	3	Some new integrated care services are evaluated but there is no systematic approach as such. Evaluation data should be readily accessible and embedded in the decision-making process and development of business plans rather than some targets to measure on. There is a plan for the development of new evaluation performance framework capturing both quantitative and qualitative data.
Breadth of Ambition	4	The ambition and vision for integrated care is set high both at national and local level. However, it is important that the wider public share these ambitions and vision as well. If looking at the current level of maturity, the integration and coordination of services is mostly on the shoulders of caregivers.
Innovation Management	3	There is a strategic plan in place to encourage innovation in the organisation, supported by the budget management. There is also new governance in place to manage the innovation more effectively. The challenge still remains how you capture the innovation e.g. what is innovative in Midlothian compared to other Partnerships or organisations.
Capacity Building	3	There is a strong commitment to the need for learning about integrated care and change management but there is no systematic approach as yet. It is a consistent problem how you build resilience and capacity while being involved in the delivery of day-to-day services. Some good examples are already in place and we need to build on them.

3 Analysis of the outcomes

1. The self-assessment outcomes reflect the actual maturity of Midlothian HSCP, showing progress towards integrated care in a number of dimensions. The outcomes provide a diverse picture of maturity, ranging between “1” to “4” in all dimensions. No results were particularly surprising to the stakeholders involved.
2. There are some connections/grouping of specific dimensions that can be observed: Q2 - Structure and Governance; Q3 Digital Infrastructure and Q6 - Removal of Inhibitors. This is particularly the case when it comes to the deployment and use of digital services. The competences for digital infrastructure are mostly at a national level which not always meet the local needs and requirements. This often discourages the use of digital services or requires more effort at the local level to deliver these services.
3. The greatest strengths were observed in a number of dimensions: Q1 - Readiness to Change, Q7 - Population Approach, Q10 - Breadth of Ambition, Q11 - Innovation Management and Q12 - Capacity-building.
4. Room for improvement was recorded for the dimensions: Q2 - Structure & Governance, Q3 - Digital Infrastructure, and Q6 - Removal of Inhibitors.
5. The factors that justified the scoring and influenced the outcomes of the maturity assessment process are mostly organisational. Most of the competences when it comes to Digital Infrastructure are at a national level with no ability to influence it from the local level. The size of the HCSP is also an important factor - the relatively smaller size of Midlothian HCSP enables the quicker establishment of new governance, service redesign or innovation management. Cultural factors also still play a role and more effort needs to be invested in change management.

4 Key messages

Stakeholders agreed that the maturity assessment process was very useful in confirming the current state of integrated care in the Midlothian HSCP. It was highlighted that the main value of the SCIROCCO Exchange tool and assessment process is not to provide an objective representation of where we are, but rather to help to prompt fruitful discussion and make people think about themselves and what they can do to improve the delivery of integrated care. The consensus-building workshop generated critical discussion but, at the same time, the Tool facilitated very good and useful conversations. Stakeholders felt that the Tool and process were easy to use and apply, however, some improvements were suggested: easier navigation on the page and clearer interpretation (description) of some of the dimensions. In terms of the outcome of the process itself, the Tool helped stakeholders to reflect on which dimensions can be influenced and improved locally, and which ones are fully dependent on national direction - which participants found very useful. Particularly, it was emphasised that the commitment to further integration and the use of digital solutions, are enablers of close and transformative working in Midlothian. Working together across organisational boundaries is essential to progress complex issues such as the co-ordination and integration of health and social care services.

5 Conclusions and next steps

The self-assessment outcomes reflect the actual maturity of Midlothian HSCP, showing progress towards integrated care in a number of dimensions such as Readiness of Change, Population Approach, Breadth of Ambition, Innovation Management and Capacity-building. In contrast, further improvement needs to be achieved in the dimensions of Structure and Governance, Digital Infrastructure and Removal of Inhibitors. A follow up meeting will be organised with the involved stakeholders to agree on the priorities for the upcoming knowledge transfer and improvement planning activities of the SCIROCCO Exchange project.

6 Annex 1 Self-Assessment Workshop in Scotland - Agenda

Workshop Objectives

- To test the methodology developed for the maturity assessment process in the EU Health Programme co-funded project SCIROCCO Exchange.
- To test the SCIROCCO tool as a tool to assess the readiness of healthcare system for integrated care.
- To inform the further refinement and improvement of the SCIROCCO tool.
- To identify the gaps and weaknesses of Scotland (and Midlothian HSCP specifically) in the adoption of integrated care and to inform about the current state of play.
- To provide a measure of the capacity of the health and care system to adopt integrated care in the form of a "radar diagram".
- To facilitate learning and exchange of experience in designing and implementing integrated care with local stakeholders in Scotland.

Expected outcomes

- Understanding of the maturity of the health and care system for the adoption of integrated care in Scotland, and Midlothian HSCP specifically, including its weaknesses and strengths.
- Reaching consensus among local stakeholders on the current state of play in integrated care in Scotland and Midlothian specifically.
- Testing of the SCIROCCO tool in Scotland and Midlothian specifically and informing its further improvement and refinement.
- Understanding the experience of users in using the SCIROCCO tool.

Agenda

Time	Session Title
09.30	Welcome, Introductions & Meeting Objectives Andrea Pavlickova, Scottish Government
09.40	Maturity assessment process in Midlothian <ul style="list-style-type: none"> Brief introduction to the organisation of maturity assessment process in Midlothian and assessment outcomes. Feedback & reflections from the local participants. Andrea Pavlickova, Scottish Government
10.00	Negotiation & Consensus Building <ul style="list-style-type: none"> Facilitator of the session will introduce the outcomes per each dimension of SCIROCCO tool and seek the consensus from the partners on the final scoring per particular dimension, including the rationale for scoring. Nessa Barry, Scottish Government
11.30	Reflection of the stakeholders on the maturity assessment process <ul style="list-style-type: none"> Moderated discussion on the experience of local stakeholders with the self-assessment process and SCIROCCO tool. Nessa Barry, Scottish Government
11.50	Conclusion and next steps Andrea Pavlickova, Scottish Government
12.00	End of meeting