HFMA – Scotland research
June 2019

Planning for health in Scotland

A regional approach

Introduction

In December 2016 the Scottish Government set out its programme to further enhance health and social care services in *Health and social care delivery plan*[1]. The plan included a commitment to put in place new arrangements for the regional planning and delivery of services.

Since then the territorial NHS boards have been working together in three regional groups, North, West and East, with the national special health boards forming a fourth working group. They have been designing and developing regional plans, setting out how services will evolve over the next 10 to 15 years in line with the *National clinical strategy*[2] and the Scottish Government's triple aim of 'better care, better health and better value'.

This briefing paper provides the context of the current position of the NHS in Scotland, outlines the objectives for each regional group and offers learning from the integrated working evolving across areas in the English NHS.

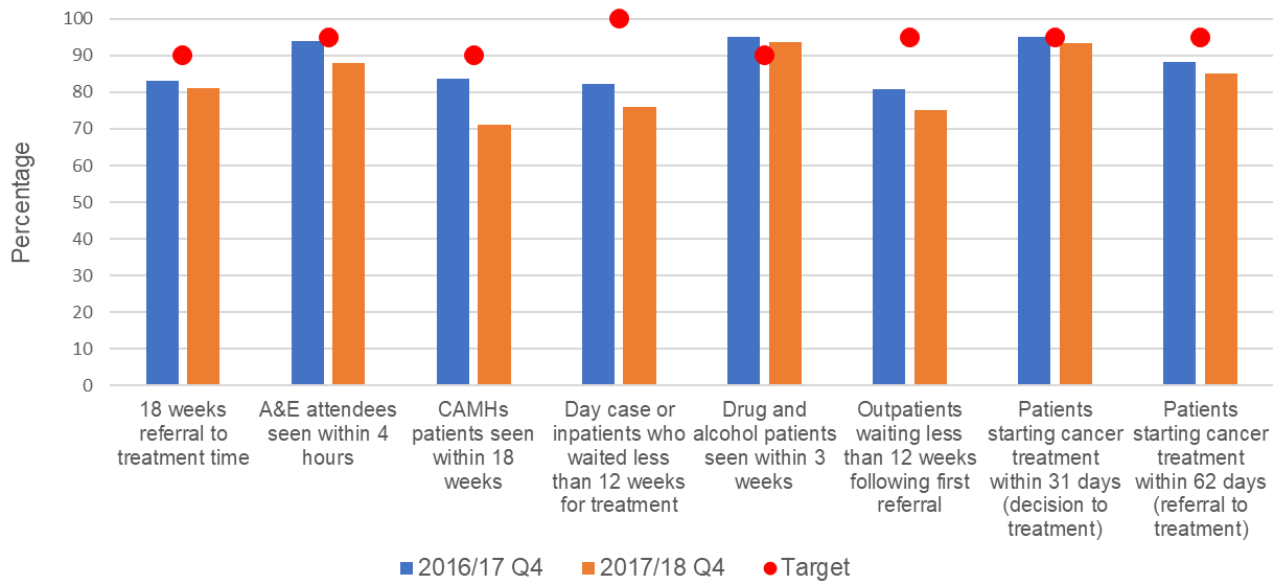
The Scottish health landscape

In 2017/18 performance against the eight key national performance targets continued to decline, with no board meeting all of the eight key national targets, and only one target being met nationally as illustrated by **Chart 1**. In addition, waiting lists continued to rise. In 2017/18 the number of people waiting more than 12 weeks for their first outpatient appointment rose by 6%, while the number waiting more than 12 weeks for an inpatient or day case procedure increased by 26%.

[1] Scottish Government, *Health and social care delivery plan*, December 2016
[2] Scottish Government, *A national clinical strategy for Scotland*, February 2016

It has been argued that the continuing focus on meeting targets in the acute sector makes it harder to achieve the longer-term aim of moving more funding and services into the community[3]. This short-term delivery versus long-term ambition conundrum, is all too familiar to the NHS as a whole, not just in Scotland.

Chart 1: NHS Scotland performance against key national performance standards 2016/17 to 2017/18



Source: Audit Scotland, *NHS in Scotland 2018*, October 2018

Financial pressures such as an increase in drug expenditure, a backlog of estates maintenance and the use of temporary staff, led NHS Scotland to struggle to break-even against an overall health budget of £13.1 billion in 2017/18. The financial pressures and the significant workforce challenges are expected to continue in future years.

The Scottish Government's *Medium-term health and social care framework*[4], published in October 2018, goes some way to providing a platform to address those challenges, but also outlines a substantial 'do nothing' gap between costs and funding.

Flexibilities announced alongside the new framework will come into effect from April 2019, allowing boards to break-even over three years rather than annually, with a 1% tolerance against annual budgets have been received as positive moves to aid longer term planning.

In addition, any brokerage given to health boards in the last five years will be written-off. The aim is to reset health boards' finances and give them headroom to move more services out of hospital and into the community.

The scale of the challenge is also clearly outlined in Audit Scotland's most recent annual review of the NHS in Scotland[5] which included five key messages:

1. An urgent need to make long-term fundamental change, rather than short-term fire-fighting
2. The NHS in Scotland is not in a financially sustainable position
3. Pressure is increasing and performance metrics are not being met
4. Clarity is needed over governance and planning levels
5. There is a critical need for effective leadership.

[3] Audit Scotland, *NHS in Scotland 2018*, paragraph 41, October 2018
[4] Scottish Government, *Medium-term health and social care framework*, October 2018
[5] Audit Scotland, *NHS in Scotland 2018*, October 2018

Audit Scotland's subsequent progress update on *Health and social care integration*[6] welcomed the collaborative improvements already achieved through the introduction of integrated joint boards (IJBs)[7], but also outlined that much more could be done. The areas identified for further development will be used later in this briefing to focus the sharing of the experiences of integration in England so far.

Regional planning

The theme of the 2018 HFMA Scottish Branch Conference was transformation and included presentations and workshops considering a wide range of topics. Whether transformation manifests itself through robotics, raising each health board up to best practice standard or planning and delivering services in a different way, it is evident that there is not one single approach to transformation. With differing health needs arising from varying demographics and geographies, some challenges will be best tackled at a territorial health board level while others may benefit from a regional approach.

Until now regional planning has very much focused on specialist services, but as Tim Davison, regional implementation lead for the East of Scotland, raised at the conference - if there isn't a realistic solution at a health board level then the challenges need to be considered by the region as a whole.

Following a review of each region's draft planning documents, and discussions with the individual regional directors of planning, the HFMA has summarised the initial regional designs below.

North Region

Population profile:

- 1.4 million people
- more dispersed than any other region in Scotland
- 25% of Scotland population in 70% of land area
- estimated 45% increase in population of pensionable age by 2037.

Configuration:

- 6 territorial NHS health boards (including 3 island boards)
- 10 integrated joint boards
- 10 local authorities
- 5 frontline national boards.

Objectives:

1. Changing demand and improving efficiency (through best practice and innovation)
2. Developing effective alliances
3. Transforming care through digital technology – 'a digitally connected system of care'
4. Developing world class health intelligence
5. Making the north the best place to work.

Specific areas of focus include:

- a consistent approach to identifying frailty in older people
- a unified system of elective care
- a single system of cancer care to maximise the opportunities for sustainability
- move toward integration of key corporate services currently operated by each of the territorial boards.

[6] Audit Scotland, *Health and social care integration – update on progress*, November 2018

[7] Integrated joint boards (also known as integration authorities or integration partnerships) are jointly accountable to Scottish Ministers, local authorities, NHS boards and the public for delivering the nationally agreed outcomes. As a separate legal body, they lead on and have devolved responsibility for the planning, commissioning and monitoring of community health and social care services and for unscheduled care acute services.

West Region

Population profile:

- 2.7 million people
- a population relatively younger than the rest of Scotland, with fewer of the very elderly
- majority of Scotland's most deprived council areas
- comparatively higher levels of care in a hospital setting than the rest of Scotland
- unexpected downward shift in life expectancy.

Configuration:

- 5 territorial NHS health boards
- 15 integrated joint boards
- 16 local authorities
- 5 frontline national boards.

Objectives:

1. Improve the health of the 2.7 million population
2. Improve patients' experiences of care
3. Achieve the best possible value in all activities (financial value and value to the patient)
4. Support and value staff

Specific areas of focus include:

- a focused workplan for children and young people's health, drugs and alcohol, obesity and Type 2 diabetes
- informed self-care and self-management, as well as better and more consistent support for carers and young carers
- a proposed stratified model for urgent and emergency care.

East Region

Population profile:

- 1.4 million people
- 25% of Scotland's population covering 10% of the land area
- 14% live in areas with the highest multi deprivation, 27% live in areas with the lowest – masking marked differences in the deprivation across the region
- 20 year gap in best and worst life expectancy.

Configuration:

- 3 territorial NHS health boards
- 6 integrated joint boards
- 6 local authorities
- 5 frontline national boards.

Objectives:

1. Shift the balance of care and investment from hospital care to primary and community care
2. Shift the emphasis of system to focus on the prevention of ill health
3. Improve access to care and treatment in unscheduled and elective care
4. Improve the quality of care and the experience that patients have
5. Deliver recurring savings each year to break-even while responding to increased demand driven by demographic change and population growth.

Specific areas of focus include:

- supporting people to look after their wellbeing and make healthier choices
- the prevention, early detection and early intervention of Type 2 diabetes
- agreed IT systems approach – assisting data sharing and to collaboration across the region
- examination of back office services in order to reduce duplication of administrative effort.

From a governance perspective, each of the regions share similar arrangements including:

- ***regional programme boards*** which provide shared system leadership and are responsible for delivering the regional programme of work. Membership includes employee directors, chief officers of IJBs, representatives from the national boards as well as senior personnel from the territorial NHS boards.
- ***NHS chairs' scrutiny and assurance groups*** which consist of territorial NHS board chairs, these groups provide oversight and high-level direction to the regional programme and ensure regional activities align with their respective health board's governance arrangements.
- ***clinical boards*** which provide professional advice to ensure there are effective clinical governance arrangements to assure quality and safety for patients.
- ***programme leads and groups*** which provide leadership in the design and delivery of the regional work plan for each functional area.

In addition, other groups featuring stakeholders from community planning partnerships, IJBs and local authorities will feed into the regional programme boards when required, as well as patient representative groups providing feedback.

No new statutory bodies have been set up to support the new regional arrangements and it is not clear what regions will be held accountable for and how, given the accountability of the individual organisations which make up the region.

Integration experiences from England

The NHS in England covers a population of over 55 million people, with 191 clinical commissioning groups procuring services from nearly 250 acute, mental health, community and ambulance service providers. The number of individual organisations responsible for NHS care in England has resulted in a degree of fragmentation. To overcome this, a 'place based' approach sees organisations working together in sustainability and transformation partnerships (STPs) and integrated care systems (ICSs).

The new *NHS long term plan*[8] identified ICSs as systems which can 'bring together local organisations to redesign care and improve population health, creating shared leadership and action.' Collaborative and integrated working as systems, rather than individual organisations, is an area that the HFMA has recently explored in depth following the creation of STPs in England.

Forty-four STPs were introduced in 2016 to bring together local NHS organisations and local authorities, on a voluntary basis, to develop proposals to improve health and the quality of care to provide better services for patients in the areas they serve.

Fourteen STPs have since developed into integrated care systems (ICS), with the intention that all STPs will eventually become an ICS. An ICS differs from an STP as a result of the organisations taking collectively responsibility for managing resources and delivering NHS standards, rather than just working closely together.

The similarities in the aims and challenges of the Scottish regions and that of English STPs are evident in the HFMA's response[9] to the Health Committee inquiry into STPs, which includes observations such as:

- not working together at scale to improve service provisions within the current level of resources is not sustainable
- STPs are not statutory bodies and individual organisations remain accountable for delivery of health services, which is presenting challenges
- the significant numbers of stakeholders involved in STPs requires strong leadership and good relationships.

Here we highlight the key challenges and lessons of integrated system working in the NHS and social care in England using the headings provided by the Audit Scotland report on integration, and

[8] NHS England and NHS Improvement, *The NHS long term plan*, January 2019
[9] HFMA, *HFMA evidence to the Health Committee's inquiry into sustainability and transformation partnerships*, January 2018

subsequently adopted by the Scottish Government's *Review of progress with integration of health and social care*[10].

Collaborative leadership and building relationships

From the outset it was evident that the significant numbers of stakeholders involved in English STPs would require strong leadership and good relationships. Particularly as STPs are a collective of local organisations without statutory powers.

The strength of working relationships within STPs has been variable across England and, especially during the initial inception, was largely relative to the strength of those relationships before the advent of STPs. Relationships with general practice, local authorities, the voluntary sector and ambulance trusts were found to be those which were less established and required further work and time to develop.

The process of working together towards a common goal/ aligned incentive has improved even well-established relationships, and we continue to see that the quality of leadership and relationships are key factors which affect whether or not progress is made.

With Audit Scotland identifying the critical need for strong leadership, the role of non-executive directors in Scotland will also need to adapt to the new regional planning arrangements. To assist with this process in England, the HFMA's Governance and Audit Committee developed a diagnostic tool on partnership working[11] (Appendix 1), which on completion can help underpin board/ governing body/ audit committee discussions by highlighting where robust arrangements are already in place and also where more work is required.

The Scottish Government's proposals to focus leadership development on shared and collaborative practice, together with calls for improved relations amongst IJB partners and also third and independent sectors are supported by HFMA and will assist regional planning. However, the experiences from English STPs, suggests the regions should not wait for national timescales to build their collaborative relationships.

Integrated finances and financial planning

One of the experiences of English STPs has been that the discussions required to agree a set of financial principles for a system, together with a written document setting them out, brings a number of benefits when aligning system plans.

Multiple board sign up is key. Agreeing financial principles facilitates early engagement and agreed processes before difficult decisions arise such as what to do if an organisation is falling behind plan, how to deal with dispute resolution and how shared savings will be used. It allows for appropriate arrangements to be developed without the heat of an issue and supports enforcement of agreed arrangements.

This understanding, together with a number of different STP examples of approaches to integrated finances and financial planning are illustrated in the HFMA briefing *How do you align resource plans across the system?*[12] including Cornwall and Isles of Scilly STP's approach to developing a financial framework.

In Cornwall and Isles of Scilly there has been a collective agreement by the chief executives and directors of finance that the health and care system will work together to support and achieve system financial sustainability. As a result, they have developed a system-wide financial framework based on collaboration and the collective view of the financial position and plan. The financial framework is four to five pages and intentionally simple and short, aiming to capture the improvement story. It sets out what needs to be done as a system by 2020/21 to achieve financial balance and includes milestones and key targets. The framework, which includes the 2018/19 control totals across the system, has been agreed at individual board level.

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[10] Scottish Government, *Review of progress with integration of health and social care*, February 2019
[11] HFMA, *Sustainability and transformation partnerships: Developing robust governance arrangements*, October 2017
[12] HFMA, *How do you align resource plans across the system?,* October 2018

Effective strategic planning for improvement

In England, both STPs and ICSs have taken a variety of forms and there is certainly no 'one size fits all'. Different models have emerged, ranging from horizontally integrated alliances of providers to vertically integrated models. The common characteristics are the involvement of an area-based alliance of organisations taking responsibility for a budget allocated to deliver a range of services to a population based on specified outcomes.

A focus on place-based care, understanding population health needs and an evidence-based investment prioritisation to improve clinical outcomes and pathway effectiveness are characteristics HFMA has found common to the health economies leading the way on integration in England.

Within their review of integration, the Scottish Government has proposed that improved strategic planning and commissioning arrangements need to be put in place by IJBs. On average there are 10 IJBs in a region therefore alignment of IJB plans for unscheduled care with regional plans requires co-ordination.

Agreed governance and accountability arrangements

In her 2018 annual review of the NHS in Scotland[13], the Auditor General for Scotland made a specific reference to governance and planning in Scotland, stating 'the overall governance of the NHS needs to be clarified for NHS staff as well as the public. Roles and responsibilities for each planning level need to be explicit and lines of accountability well defined. NHS boards need better support to govern and challenge effectively.'

As Scottish programme boards are not legal entities, there is potential for conflicts of interest to arise between the aspirations of a regional plan and the performance targets of a statutory territorial health board. To address this, and for long-term fundamental transformation to be prioritised over short-term fire-fighting, robust, clearly defined governance arrangements will be essential.

Alignment of STP decision-making with organisational accountability has also been a key governance concern in England, largely due to STPs not being statutory bodies. The need to develop a system-wide approach, while retaining the existing architecture of separate organisations led to a lack of clear accountability for delivery and decision-making in some areas.

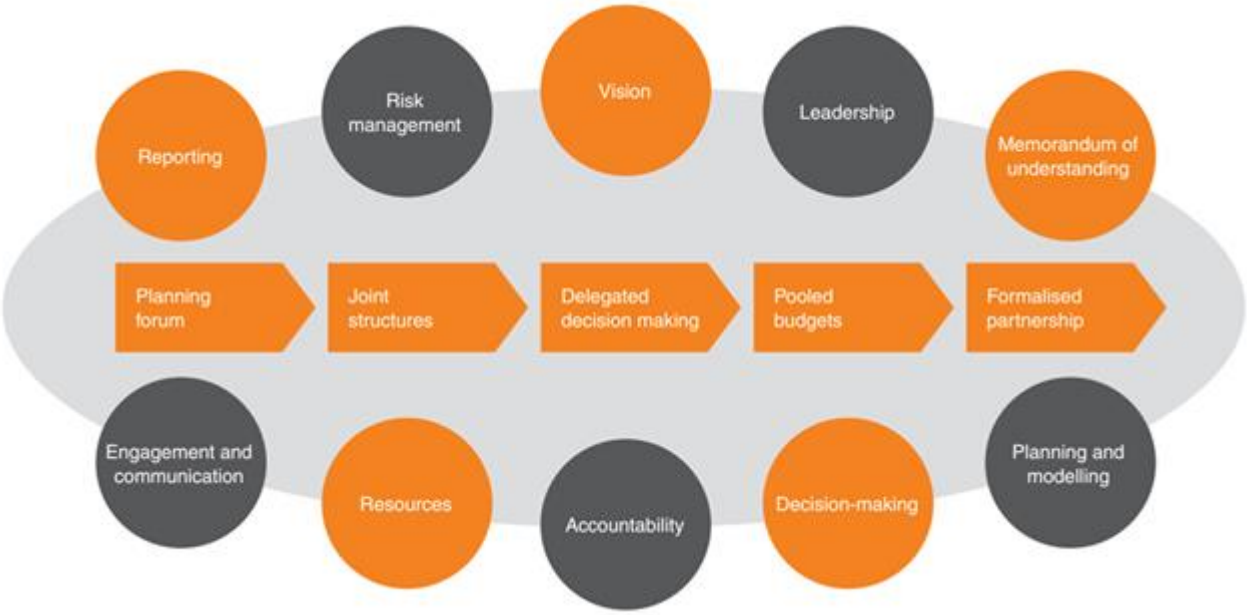
It is unsurprising then, that the development of non-statutory governance arrangements to support collective decision-making (including assurance and communication links to non-executive directors, CCG lay members and councillors) was found to be a common feature of areas integrating well.

As part of the HFMA's review of developing STP governance arrangements[14], ten key governance elements were identified (**Chart 2**), each of which need to be in place and working effectively to properly support STP governance models.

Our research found that identifying and discussing the key elements of strong governance (represented by the circles in Chart 2), supported leaders from different organisations with mutually dependant challenges and aims, to understand the governance arrangements required for their journey from planning through to a formalised partnership (the middle section of Chart 2). And while the component organisations in Scotland may differ slightly, the aim of multiple bodies achieving a variety of population-based outcomes through aligned planning and delivery is shared.

[13] Audit Scotland, *NHS in Scotland 2018*, key message 4, page 23, October 2018
[14] HFMA, *Emerging approaches: Developing sustainability and transformation plan governance arrangements*, March 2017

Chart 2: Governance spectrum and supporting key elements



Additionally, the *HFMA corporate governance map*[15] has been devised to provide links to key guidance and tools to support effective corporate governance within the NHS and includes a section specific to Scotland.

Ability and willingness to share information

A good understanding of costs across the system is essential to alignment, avoiding duplication or omissions. This requires easy to understand, and easy to access, good quality information. The information requirements and sources should be agreed upfront to support alignment and monitoring.

There is a wealth of data available, particularly in areas that are easy to measure, but the system needs to ensure it is meaningful. In many cases, the local authority may already measure things that matter to the population and support resource plans aimed at improving overall population health.

A clear digital framework has been evident in many of the new ICSs in England, with examples of information teams from partner organisations working as one team to develop appropriate data collection systems to meet the information needs of the whole system rather than individual organisations.

Meaningful and sustained engagement

In England, there have been mixed levels of engagement with the public, patients and staff. In many cases, a lack of transparency led to a view that STPs could purely be a mechanism for cost-cutting. The HFMA's STP governance survey[16] also found the lack of engagement with NEDs and lay members to be a concern.

However, for those areas where STPs have developed into ICSs, transparency, together with a clearly articulated vision and set of goals, were key contributing factors to the STP beginning to work well. The engagement must be meaningful and include patients, carers, the public and their representatives. Ideally the plans should be co-produced with patients and the public, but for some, the speed at which the plans were developed did not easily facilitate this.

We believe that public engagement needs to be based on a clear 'case for change', what the changes mean for patients and how outcomes are expected to improve. How the changes will lead to improved value for patients and taxpayers should be a key strand.

[15] HFMA, *NHS corporate governance map*, September 2018
[16] HFMA, *STP governance survey findings*, March 2018

Next steps

Each of the regions describe the development of their regional plans as an ongoing process, with the next stage being one of communication and engagement with patients, carers, third sector organisations and the professional bodies such as the health unions.

After this engagement period, and a thorough appraisal of the impact of the medium-term financial framework, a detailed set of plans will be submitted to the Scottish Government for approval during 2019.

If the current experiences of STPs and ICSs in England are anything to go by, it will be the people and the relationships which will provide the greatest influence in determining whether regional planning will be successful in improving the health of the population.

Robust governance structures will enable change and provide a pathway for some of the more difficult decisions which lie ahead, and the strength of unity from regional and national leaders will dictate the pace and nature of the journey for NHS Scotland.

Appendix 1: Governance diagnostic tool

The questions set out below are comprehensive and focus on the greatest risks in the governance process whilst not becoming so numerous as to be unwieldy (depending on the local situation it may not be necessary to have all the items in the tool in place). The answers to the questions are rated red, amber or green. An example is provided below:

Questions	Red	Amber	Green
Are data sharing arrangements in place?	No	Planned for next 6 months	Yes
Has a memorandum of understanding been established and agreed by all parties?	No	Planned for next 6 months	Yes
Has the partnership agreed who has decision-making powers?	No	Yes, but we don't know what they are	Yes, and we know what they are

The benefits come from working through the questions and discussing the output within the organisation and with partners. Each area of the tool has a main question for consideration and further areas to facilitate discussion. The exercise will also enable organisations to identify areas for further work to secure appropriate assurance. This will focus attention on whether governance arrangements for working together at scale are robust.

Questions	Red	Amber	Green
Clinical quality: are you assured that the changes are clinically beneficial? • Are there clear clinical transformational benefits? • Are clinical outcomes properly understood? • Is quality maintained or improved as a result of the complex contract? • Are patients fully engaged?			
Vision: is there an agreed and common purpose? • Has this vision been shared? • Have stakeholders confirmed they support the vision? • Have stakeholders made a commitment to help deliver the vision? • If a complex contract is involved, is there a clear strategic rationale for it?			
Leadership: are you assured that there is appropriate and strong leadership in place? • Have all leaders been appointed? • Is there the capability and capacity to transform and deliver? • Does the regional board have the capability, capacity and experience to deliver the strategy?			

• Has an appropriate leadership structure been agreed for the regional board? • Has the regional board considered whether any more formalised partnerships are appropriate? • Does the regional board have sufficient buy-in from senior management within the individual organisations to achieve its objectives? • Are processes in place to manage any transition?			

Memorandum of understanding (MOU): has an MOU been established and agreed?
• Is there clear documentation of the governance structure?
  • is the governance and management appropriate?
  • does this include committees/ groups in place and how they interlink?
  • does this include who is represented on the board/ committee?
  • does this include any formalised partnerships in place/ planned?
• Is the governance assurance process set out?
• Are roles and responsibilities defined?
• Does the MOU detail how often meetings take place?
• Are any delegations clearly set out in formal schemes of delegation (individual bodies and the regional board)?
• Are conflict resolution arrangements agreed and documented?
• Do arrangements ensure that all organisations are not at risk of breaching statutory duties?			

Engagement and communication: are you assured that appropriate measures are in place? • Has the plan been published? • Has there been or is there planned public/ patient involvement? • Has there been or is there planned clinical involvement? • Do plans clearly communicate what changes mean for patient experience and outcomes and help explain efficiency savings and the impact on patients? • Is there a communications plan in place? • Does the communications plan cover both internal and external audiences? • Does the communication strategy support meaningful engagement with patients, carers, the public and their representatives across all appropriate populations?			

• Does your engagement plan clearly link to existing plans, demonstrate those areas which are continuations of existing plans and those which are new ideas? • Have individual organisations set up appropriate assurance arrangements to ensure they are actively being engaged with, appropriate evidence-based decision making exists, and appropriate information flows are in place?			
Planning: are you certain that the plan is based on a clear understanding of the existing position and where you want to be? • Has planning been aligned with, or taken due account of, each organisation's strategic and business planning? • Has any sensitivity analysis been carried out? • Are the contracted services financially sustainable? • Is there a clear workstream development plan in place to deliver the vision with clear and agreed outcomes, milestones and leads beyond planning and set up arrangements? • Has the regional board agreed who approves the overall plan and changes?			
Decision-making: are you assured how decision-making will work? • Who has decision-making powers? • Are these set out in a scheme of delegation? • Has the regional board agreed how stakeholders are represented through the decision-making process? • Are there arrangements in place for leaders to involve partner organisations throughout the decision-making process? • For each type of decision, has it been agreed who will be involved, how many people need to agree and if this is in accordance with individual schemes of delegation? • Where appropriate, have delegated powers been sought and agreed? • Are arrangements in place to ensure decisions are evidence based? • Are decisions required to be informed by quality impact assessments? • Are arrangements in place to determine how collective decisions will be reached, through respective schemes of delegation? • Are arrangements set out in the MOU? • Are procedures in place to identify and manage potential conflicts of interest?			

Resources: is the arrangement appropriately resourced? • Has resource for management arrangements from the partner organisations been agreed? Is the control total agreed? • Are there either full time team members working or sufficient capacity created from existing workloads? • Has the regional board considered whether financial resources are at an appropriate level? • Has the operation of financial flows within the regional board been agreed? • Is the procurement and contract documentation appropriate? • Are existing or planned pooled budget arrangements and responsibilities clearly documented? • Have funding plans been reconciled to individual organisational plans? • Have capital investment requirements been determined and taken forward? • Has the regional board agreed how gains are shared equally amongst participants - for example, covering stranded costs? • Have shared financial frameworks and other financial management processes been established?			
Reporting: are you assured that internal and external reporting arrangements are in place and will deliver? • Have all appropriate returns been agreed and submitted to regulators? • Have governance arrangements been reported internally to individual boards and governing bodies? • Are arrangements in place to ensure any governance changes are reflected in individual organisation annual reports and annual governance statements? • Are data sharing arrangements in place? • Are data quality assurance arrangements in place? • Does the structure mitigate potential duplication of review and reporting? • Is there a sufficiently clear thread linking action plans, milestones and progress updates? • Are reporting arrangements covered in the MOU?			

Risk management: are risk management arrangements in place? • Have legal risks been identified and mitigated? • Has the regional board agreed which risks can be shared and how will they be managed? • Does the regional board have a risk register? • Are the risks included on individual organisation risk registers? • Is there a clear process for identifying emerging risks during the implementation phase?			