DISTINCT PROFESSIONS; SHARED CARE

A professional leaders' forum on the transition to integration

28 April 2015, Crowne Plaza, Glasgow

A report of discussion by the event hosts: The Royal College of Nursing, Scotland.

The conference

On the 28th April 2015, just as the Scottish integration reforms went live, the RCN hosted a major inter-professional conference in central Glasgow to explore the key issues that the regulated professions face and to find shared solutions. This was part of a Scottish Government grant to the RCN to support leadership in integration over 2014-15. The event was also supported by the following professional organisations: RCGP Scotland; Scottish Executive Nurse Directors; Social Work Scotland; AHP Federation Scotland; Royal Pharmaceutical Society Scotland, and the Academy of Medical Royal Colleges and Faculties in Scotland. Rt Hon Henry McLeish chaired the day.

Over 110 delegates from across Scotland spent the morning in detailed discussions on hot topics set by leaders from each of the professional bodies. During the afternoon Health Scotland and Inclusion Scotland set out thoughts on how the principles for integration in the Public Bodies Act might change services and professional practice in the future. Professional leads from Scottish Government led themed discussions ranging from the future of OOH services to integrated assessment and decision making. Lively debate featured across the entire day.

The conference was intended to support a culture of understanding and respect between the professions, within a relatively safe space, with a specific focus on the needs of those staff who work within the context of individual professional regulation. This led to some concerns on the day that partners in the third and independent sectors, as well as people using services themselves, were absent. This was intentional, but the criticisms were clear and perhaps, should the Scottish Government wish to follow up on calls for a repeat event next year, this could be addressed.

This report is intended to highlight the key issues that were raised through discussions on the day. They do not necessarily represent the individual

views of any of the organisations involved in the event. We hope that participants will recognise these key themes from their own discussions.

Overarching messages

The day showed that the professions are eager to see services improve for the people who use them and to find creative solutions to the problems they face in delivering them. As one group noted: people aren't being told to change; they are coming to managers to ask for it. There was a plea that we all remember that we are not starting from the beginning and that we should not lose, through the transition, those things that already work well.

Participants shared a commitment to a values based approach to integrating health and social care, rooted in improving outcomes for anyone who requires the support of professionals. However, a strong theme of the day which emerged from both small discussions and key note speakers was that the misunderstandings arising from the different language used by professions and sectors are a significant risk to integration working in practice. In closing the conference, Paul Gray (Director General of Health and Social Care and Chief Executive NHSScotland, Scottish Government) urged delegates not to take offence with each other by assuming ill intent in the use of words that may sound inappropriate to one person, but perfectly fine to another. Instead, he asked staff to find ways to ask open and respectful questions of each other to truly understand what lies behind a word or phrase as we bring cultures together.

As the debates and conversations progressed over the day, delegates commented on just how similar their challenges are and that no single profession has an answer to making these changes work. In the evaluation of the event we asked respondents to note the most important action they would take from the day. Answers focused on:

- sharing their improved understanding of common issues in their own teams
- fostering better, stronger, open relationships with colleagues in their own area
- being persistent in attempts to get engaged with local activities
- keeping an open mind

Discussions about improved understanding on the day went beyond professional boundaries to focus repeatedly on the need to engage both the public and the media in decisions about radical reforms. Participants noted that without their understanding and support, political resistance to significant change will bring integration ambitions to a standstill.

Participants also noted that the national direction had now been set, but that the local activity required to implement change over the next 12 months is immense and causing real tension. Some noted that a focus on legislation and on the practical, contractual structuring of (integrated joint boards) IJBs can get in the way of improving joint working on the ground.

Finally, we note that most of the detail of the discussions noted below will not come as a great surprise to anyone who has been involved in the development of the integration project over the last few years in Scotland. That in itself is noteworthy. Those working on the frontline – and committed enough to these reforms to attend this conference – still feel the need to bring the same issues we have heard many times to the fore, with just a year to go to complete the transition. The Scottish Government and IJBs cannot afford to lose the enthusiasm and commitment of this workforce by failing to act on the practical needs, concerns and ideas of those delivering health and care services to communities across Scotland.

The detail of the discussions

1. Planning the current and future workforce

1.1. There are significant shortages in some parts of the existing workforce and, in some professions, a fast-ageing workforce. We need to work quickly to recruit and retain professional staff effectively. However, pharmacists at the event, uniquely, noted an oversupply of new graduates at this point in time. These need to be utilised swiftly to help deliver better integration before they are lost to the profession.

1.2. We have to plan our workforce far more coherently and be clear what we want our combined workforce to do. New models of care in integrated teams require joined up workforce planning across professions based on far more accurate intelligence on the existing workforce.

1.3. New models of care for the future need investment in professional role development now. Training and developing an expert workforce takes time.

1.4. We need to understand how IJB plans will link to, or change, the existing models of NHS workforce planning, which are used to plan nationally. There is not the same structure of national planning requirements within councils at this point in time.

1.5. The workforce is not limited to the statutory sector. All discussions on future workforce must take into account the current and future workforce needs of third and independent sector partners. Developing a truly integrated workforce also needs to take into account, and help to build, the capacity of the local community.

1.6. A long-term approach to integrated workforce planning must be built on good evidence, which requires robust data across sectors. This is not always currently available.

1.7. There is competition for staff in some markets, which is impacting negatively on the workforce's ability to deliver.

1.8. Tensions remain in some areas over variations in terms and conditions across sectors and professions.

1.9. Changes to ways of working will result in significant changes to skill mix – both between and within professions – as we ensure the right people with the right skills are in place for someone's entire journey through the health and social care service. This will require staff to take on new skills, which will require commitment to training.

1.10. Higher Education Institutes must be engaged in changes to be able to deliver the right education for professionals.

1.11. Discussions focused on better training of support workers at one end, to increased investment in advanced practitioners to allow better decision making in the community, at the other. There is concern that there will not be adequate funding made available for this.

1.12. Professionals must be empowered – and trained - to make decisions. There must be time for staff to engage in professional supervision that supports their practice.

1.13. We must acknowledge that both inter- and intra-professional assumptions can box professions into a particular way of working. The professions will have to challenge their own historic perceptions of their remits and be willing to give some things up to focus on the particular expertise they alone can bring. Sometimes a lack of understanding of other professionals' roles can result in individuals taking on activities that could be better done by others.

1.14. There are concerns that an already stretched workforce may struggle to cope with the additional workload in the transition.

1.15. Plans must take into account the changing expectations of the emerging workforce, every bit as much as the changing expectations of the public. One example given was of younger doctors, who may be less likely to choose to work out of hours than older doctors who had historically delivered these services before the GP contract changed.

1.16. We should capitalise on opportunities to support those just entering the professions to improve integrated care, as without them we will not have long-term change. They will be the drivers of change. Training programmes for the regulated professions must embed integrated ways of working.

1.17. The culture and planning of the workforce should be embedded in the principle that everyone works to the "top of their license" in a multi-disciplinary and multi-agency team.

1.18. If Local Authorities and NHS boards develop new jobs to deliver integrated care – such as new management posts – they need to

consider doing this in tandem to avoid perceptions of a “take over”, simply because one partner has moved to define and appoint posts more quickly and management roles are therefore weighted to either health or social care. Management should be balanced across the sectors.

2. Changing services

2.1. Services must be based on assessed local need and embed outcomes as the focus for bringing professions together.

2.2. The focus on professional input must avoid medicalising normal life – we should be focusing on establishing the building blocks of a healthy life, wherever possible.

2.3. Localities could give professions – along with local people – an excellent opportunity to shape better services. They could also be used to drive the definitions of professional contributions that we also need. However, some concerns were raised about how to ensure genuine engagement.

2.4. People needing to use services require a single professional point of contact to help them navigate the system and co-ordinate care.

2.5. Ensuring continuity of care should be a central focus in service development.

2.6. Individuals agreeing to increase their self-management and share risk are key to changing how services are designed and delivered.

2.7. Ongoing tensions between genuine investment in prevention and continued spend on crisis-based hospital interventions, have to be tackled for the integration project to improve care. People are being discharged from hospital while they still need significant clinical care, but there is no resource transfer to accompany this change.

2.8. There are currently insufficient specialist services in some areas to direct people to.

2.9. Inadequate resources for community services – and how to better use existing community assets - were raised throughout the various discussions and evaluation as an ongoing concern.

2.10. We need to review the impact of new services on existing services. We also need to ensure robust cost / benefit analysis of new services to allow difficult decisions to be taken on the basis of sound evidence. Better evaluation of service change is required.

2.11. There may be difficult conversations to have about what should be provided locally and what regionally or nationally.

2.12. Changes are needed to the availability of services for people who require them. Once there is a clear understanding of which services should be provided on a 24/7 basis, all professions need to be resourced to operate to make these work in an integrated way.

2.13. There needs to be clear discussion on what out of hours services are there to provide and what it is reasonable for people to be able to access in unsocial hours. Once this is decided, a public education campaign will be essential to change behaviour. What is classed as 'out of hours' has not changed for some time, but parallel discussions are taking place around 24/7 working. Clarity is needed from the top.

2.14. If people are in crisis outwith core hours, they should not have to jump through "burning hoops" to get a service. There are examples of good out of hours care in mental health, for example, that could provide helpful models.

2.15. Social workers reported feeling isolated from out of hours services.

2.16. There is a real opportunity to trial new, inter-disciplinary ways of working out of hours.

2.17. Better use and sharing of anticipatory care plans are essential to improving out of hours care.

2.18. Different areas of current service are at very different stages of integrating care and shifting the balance of services to community settings. More could be done to learn from both mental health reforms and the implementation of GIRFEC.

2.19. There are concerns about the impact of eligibility criteria on future services and whether these are, or will be, consistent (or applied consistently).

2.20. There are differences in understandings of how an integrated team should operate, with some focusing on bringing staff together through co-located hubs and others suggesting the focus should be on ways of working, not buildings.

2.21. Measurement of current service success is too focused on the hospital sector.

2.22. For professions to truly integrate they need far more systematic knowledge of the available networks to help people using services to get a fully rounded service. "Network literacy" needs to be a core part of local integration developments.

2.23. The squeeze on local government finances and the ongoing difficulty of freeing acute resources may have a significant impact on reforms which require an "invest to save" approach.

2.24. The recently announced national clinical strategy could have a significant impact and this is an important time for the regulated professions to influence it.

3. Professional identity

3.1. Integration is not about creating a single professional role; it is about bringing professionals together to better meet the needs of an individual. This does not need to mean a loss of identity, though some participants were concerned that it might.

3.2. We must value expertise – whether that expertise is provided in specialist or generalist roles. We may need to re-consider how, in the NHS, Agenda for Change is used to recognise the value of generalist roles. We also need to challenge professional and public perceptions that only specialists, and not generalists, can help.

3.3. We need to better explain the value our professions can bring to integration. Each profession needs to explore and understand this for itself and not lose what is good. But we also need to ask what others can do too and listen to that. Mutual respect comes from mutual understanding.

3.4. We need to avoid duplication of effort. This will require professions to work together to discuss how, where the edges of roles do blur, activities and accountabilities are clear.

3.5. Which professional is relevant in any one situation should be determined solely by the needs of the individual requiring care and support.

3.6. Professionals do need support in the “how” of bringing together different models and cultures. This is new for everyone.

3.7. Support staff across health and social care must be valued. They need both a robust career structure and pay that recognises their contribution. We shouldn’t be losing support staff to supermarkets because they can be better paid stacking shelves.

3.8. We still need to address the disparity in regulation for support staff in health, who are not regulated, and in social care, who are.

4. Accountability and leadership

4.1. Good governance is essential to the safety and standards of integrated care.

4.2. Each profession needs a ‘professional golden thread’ from the frontline to the very top of the governance structure to provide assurance, accountability and support for their work. This is

separate from general management structures, which can be multi-disciplinary in nature.

4.3. Integrating partners and their staff need to explore and understand the differences in regulatory requirements between professionals and ensure that staff members are clear about the levels and scopes of practice across the integrated team. This would, for example, make clearer the points of referral between professions for a person using the service.

4.4. Robust clinical and care governance is a risk enabler – which is essential given the changes required.

4.5. Changing ways of working and extending / advancing practice will require new approaches to risk and responsibility from all involved, particularly as more risk may be held by those using services who are taking more active decisions in their care and self-managing conditions. Different professions – and even different parts of one profession – are at different places in their assessments of shared risk. Change here is very much linked to other comments on the lack of shared language causing barriers. Time is needed for partners and frontline staff to find a shared perspective on risk.

4.6. Better frameworks for "autonomous practice behind closed doors" are needed in this new landscape of far more complex, home-based care.

4.7. Questions remain about the integrated governance of services provided or hosted outwith the two statutory partners.

4.8. Staff members need to be supported to ensure that they understand how to delegate appropriately, within their individual professional codes, within this more complex environment.

4.9. Partnerships must genuinely learn from adverse events to ensure services improve.

4.10. Competencies and frameworks for all non-registered staff are required.

4.11. There are concerns that there is duplication or confusion of effort with 31 frameworks for accountability, professional leadership and governance being drawn up as part of the transition.

4.12. Professions who require re-validation with their professional body must be supported to do this, whatever sector they work in.

4.13. There are also concerns about how to marry up two different scrutiny bodies and processes at work between health and social care.

4.14. There are clear anxieties among professionals about the fragility of integrated care and clinical governance arrangements for integration. A clear focus on governance is required from the top.

5. Staff Engagement

5.1. Staff engagement is key – not only to acknowledging the importance and experience of staff members in delivering change, but because a demoralised and disengaged workforce will negatively impact on people using services.

5.2. Staff are our greatest assets but we must acknowledge that they may feel vulnerable at the moment. Fear of losing voice or control will result in defensiveness among staff. This should be openly addressed.

5.3. All professionals need the resources and support to attend meetings and training opportunities that will allow them to be fully engaged in the process within partnerships. Frontline staff cannot just walk away from the people needing their services without proper backfill, for example.

5.4. The support for staff to get engaged in integration must be sustained and not made available piecemeal.

5.5. Engaging frontline staff in strategic reform needs a good story to explain the changes and impacts.

5.6. Whilst acute-sector doctors, GPs and nurses are now represented on the IJBs, the other professions are not and will have to work harder to be heard at strategic level. Even for those professions who are represented, there are concerns about how one individual will provide sufficiently robust leadership in the new structures.

5.7. Poor management of change causes staff fatigue and loss of engagement. This process of transition must be managed well to succeed. Organisational Development colleagues are key to success.

5.8. There are still members of staff, particularly in the acute sector, who simply do not have integration on their horizon – even within those parts of the acute sector that are included in the IJB's remit.

6. The tools for the job

6.1. IT systems set how professionals work – with service users and with each other.

6.2. Poor IT infrastructure, lack of mobile coverage and the continued absence of shared records – even between different parts of the health service – remain a fundamental barrier to good integrated

working and improvements in the care and support offered to the public. Professionals need the right information at their fingertips to make the best possible decisions – not having this exposes both staff and people using services to unnecessary risk.

6.3. There are differences of opinion on whether the answer is to focus on records held by individuals or on developing a single/integrated individual record held across organisations.

6.4. IT, where it is available, is not always well maintained, which results in both time and resources being wasted.

6.5. There are genuine issues to be addressed about the appropriate handling of sensitive personal data, but some participants noted that there are cases where professionals approach sharing data with a level of protectionism about the information. There are clearly ways to ensure limited access to certain data where that is genuinely required. Good governance is essential. If this were in place, it would allay the fears of some staff about the misinterpretation or misuse of data.

6.6. Professionals will need to be open and honest with people using services about data sharing.

The RCN would like to thank all the organisations who were involved in shaping and delivering the conference programme and all the individuals who attended and participated so fully in discussions. We are also grateful to the Rt Hon Henry McLeish, who chaired the day.

Finally, our thanks go to the Scottish Government for providing funding for this event. We hope this output will help them in providing support for implementing integration successfully across Scotland.

RCN, 2015

Appendix 1: Evaluation

Fifty-three delegates (almost 50% of attendees) completed an online evaluation of the event, which the RCN sent to them by email as the conference closed. The vast majority of respondents were nurses and AHPs, which mirrored the make-up of delegate.

Of those who responded, 91% rated the conference as good or excellent.

Participants noted that they valued:

- the opportunity to network with a broad range of other professions
- the chance to engage in in-depth conversation
- the opportunity to hear other perspectives on and experiences of , integration beyond those in their own locality
- sharing ideas
- the vision of some of the speakers
- the focus on multi-disciplinary approaches.

When asked what they would like to have been different, a number of respondents noted “nothing” or made comments like “more time!”, but where issues did arise they can be themed as:

- The day would have been improved by service user and independent / third sector involvement
- A greater focus on existing good practice being shared, both from Scotland and from further afield.
- Better structure to some of the discussions
- Some comments that some discussions were weighted too heavily to one aspect of service
- The large venue impacting negatively on sightlines, acoustics and temperature.
- Finding the ordering of the Twitter feed unhelpful

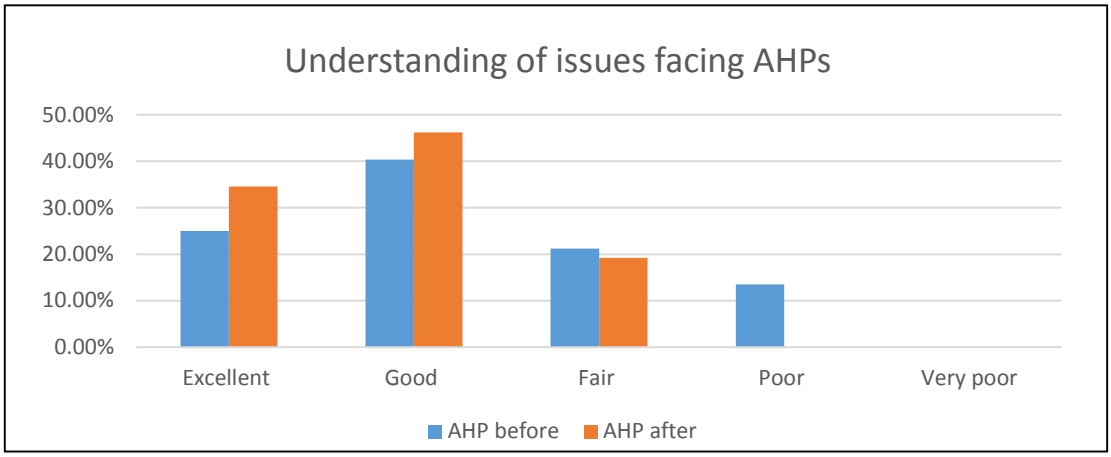
The event was partly intended to improve understanding between professions. We asked delegates to rate their understanding of the issues facing each profession before and after the event to assess this outcome. For each profession, good and excellent understanding increased as a result of the conference. Tables are included for each profession on pages 12-13.

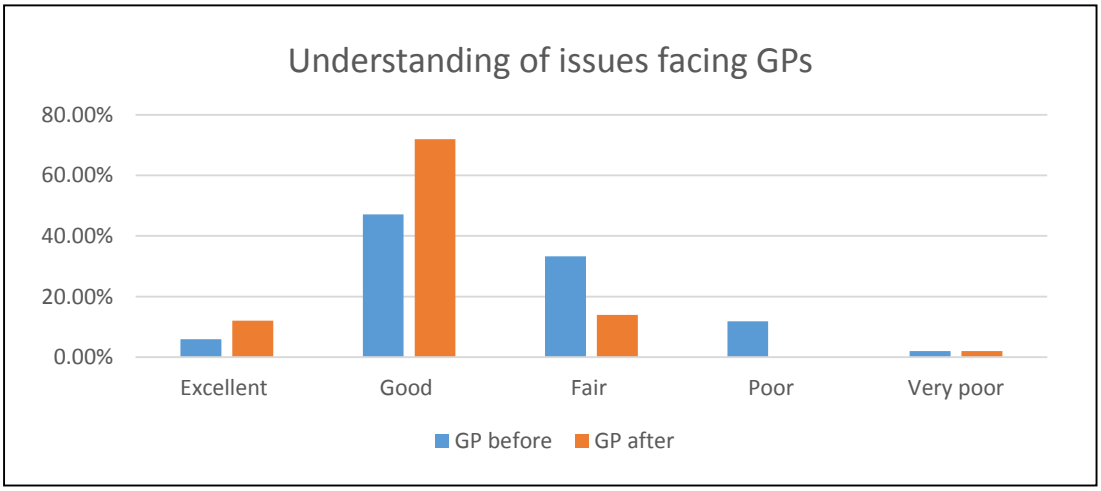
As part of the evaluation we asked three further questions, with the opportunity to answer in free text boxes:

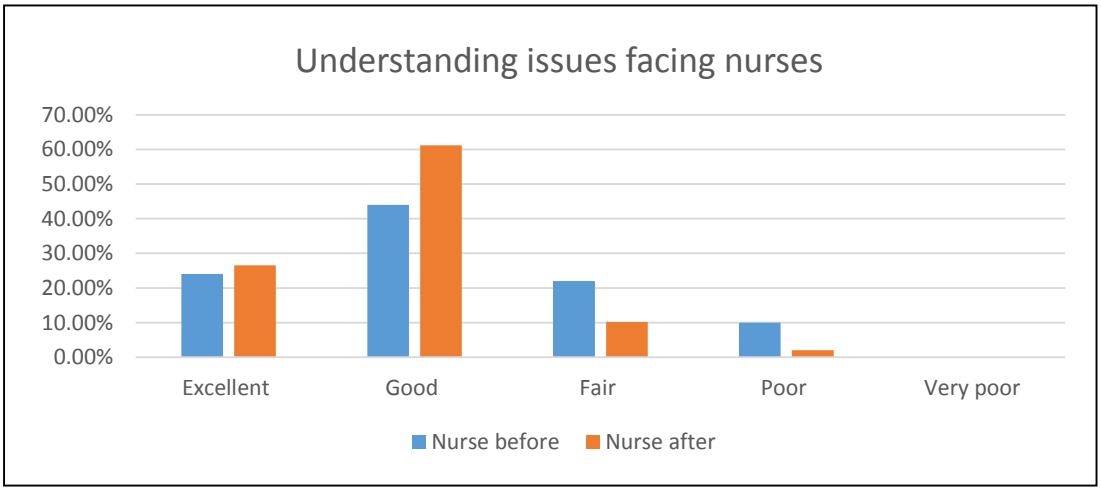
1. What is the most pressing question that you think still need to be addressed for integration to be a success?
2. What is the most important thing you learned about a fellow profession today?
3. What is the one most important action that you will take away from the event

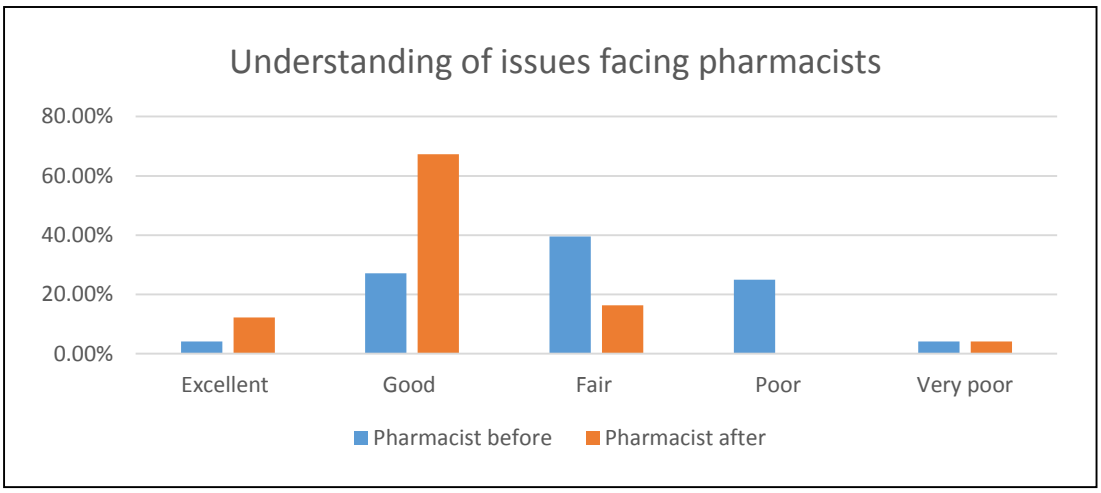
Delegates responded fully and we have incorporated many of the key themes that arose in these responses in the full body of the report.

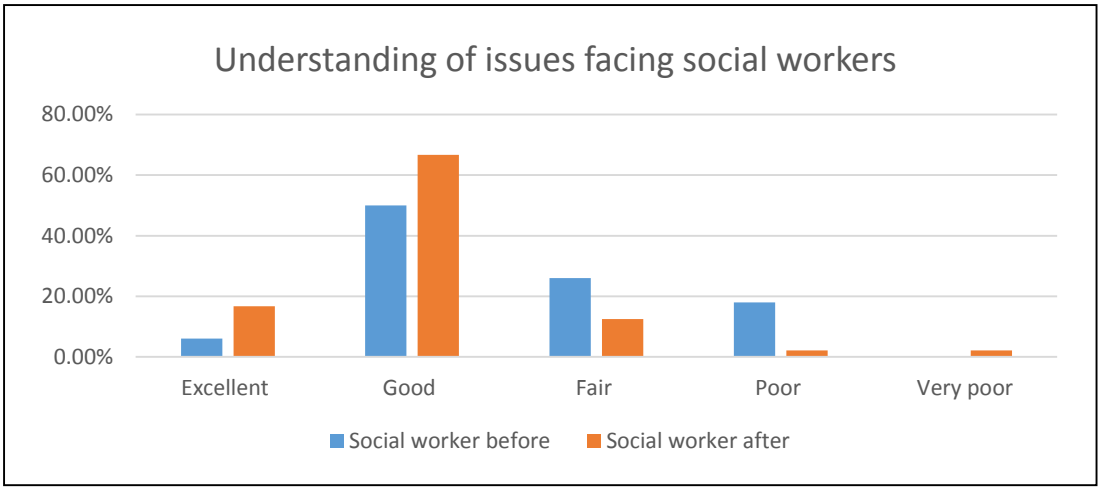
Delegates understanding of the issues facing each profession.

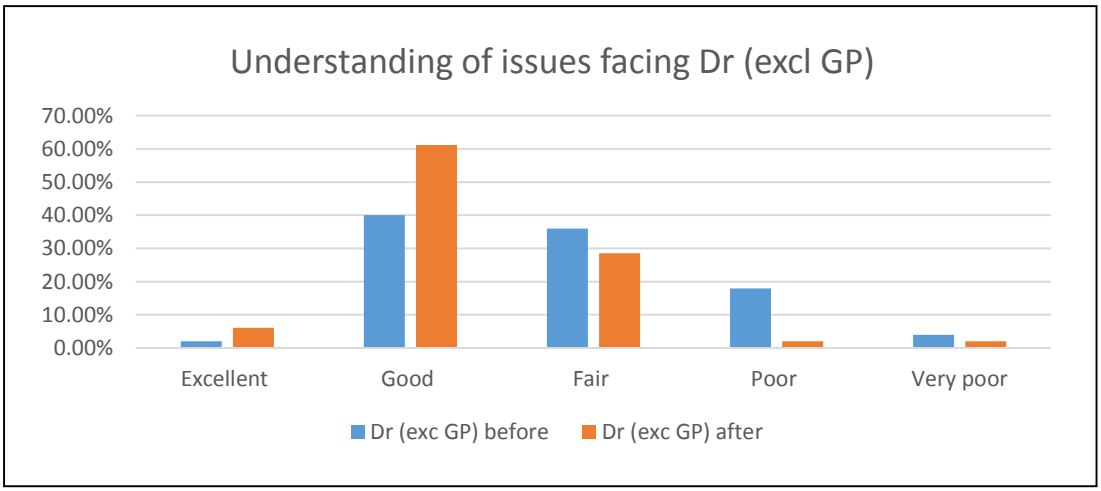







Understanding of issues facing pharmacists
80.00%
60.00%
40.00%
20.00%
0.00%
Excellent
Good
Fair
Poor
Very poor
Pharmacist before
Pharmacist after


Understanding of issues facing social workers
80.00%
60.00%
40.00%
20.00%
0.00%
Excellent
Good
Fair
Poor
Very poor
Social worker before
Social worker after


Understanding of issues facing Dr (excl GP)
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Excellent
Good
Fair
Poor
Very poor
Dr (exc GP) before
Dr (exc GP) after

Appendix 2: Programme

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PROGRAMME

9.15am	**Coffee and Registration**
9.45am	**Welcome to the day** Theresa Fyffe, RCN Scotland
9.50am	**Introduction and personal reflections on integration** Chair: Rt Hon Henry McLeish
10.00am	**Burning issues for the professions at the point of transition** Speakers include: Dr Miles Mack (RCGP), Prof Hazel Borland (Scottish Executive Nurse Directors), Harry Stevenson (Social Work Scotland), Mr Ian Ritchie (Academy of Medical Royal Colleges and Faculties in Scotland), Alex MacKinnon (Royal Pharmaceutical Society, Scotland), Kim Hartley (AHP Federation Scotland)
10.35am	**Discussion time**
11.05am	**Coffee**
11.25am	**Debating the burning issues across professions** Facilitated round table discussions
12.25pm	**Reflections on the discussion** Rt Hon Henry McLeish
12.40pm	**Lunch**
1.50pm	**Using the principles of integration to change behaviours and relationships – two perspectives for the professions** Dr Sally Witcher (Inclusion Scotland) and Pauline Craig (NHS Health Scotland)
2.15pm	**Q&A** Dr Sally Witcher, Pauline Craig and Rt Hon Henry McLeish
2.35pm	**Workshops: Working across professions to improve care – practice based ideas** Topics include: professional accountability and leadership; approaches to risk, safety & control; planning for an integrated workforce
3.45pm	**Closing address** Paul Gray, Director General of Health and Social Care and NHS Scotland Chief Executive, Scottish Government
4pm	**Coffee, cake and networking**