Royal College of Nursing
Scotland

ROYAL COLLEGE OF NURSING SCOTLAND

Emerging Directions: An analysis of Scottish integration authority strategic plans with a focus on nursing and health care issues

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PREFACE

In the summer of 2016, RCN Scotland commissioned Eileen Moir of Turning Tides to review all 31 integration authority (IA) strategic commissioning plans. These plans had all to be completed by April 2016 as the Public Bodies (Joint Working) (Scotland) Act 2014 was fully commenced. The RCN wanted to understand what these first set of formal plans said about the future of health and care services and nursing in order to shape the future work of the College in this changing landscape.

The report which follows is based on the analysis and personal reflections of the author; they do not necessarily represent the views of the RCN. However, the RCN hopes that the themes and questions presented are helpful as all partners work to understand and influence the shape of integrated care in Scotland.

1. INTRODUCTION

The context for nursing is changing - perhaps more than we've ever seen before. People are living longer. The number of over 75 year olds is predicted to increase by over 25% in the next 10 years. While many will enjoy good health in their later years, it is estimated that at least two thirds of people will have developed a long term condition by the age of 65. The demand for health and care services will therefore increase year on year in line with the predicted longevity[1]. Scotland is not alone; other countries are grappling with similar issues.

Then there is digitalisation which marks the biggest societal shift since the industrial revolution. The rise in the use of technology in daily life and social organisation has become the driving force of social evolution[2]. Future generations' access to information and their expectations of health and care services will be significantly different from that of their predecessors[3].

To remain viable, health and social care in Scotland must keep pace with these changes within a context of increasing financial restrictions. The Public Bodies (Joint Working)(Scotland) Act 2014, which requires NHS boards and Local Authorities to integrate certain adult health and social care services, is one of the vehicles for delivering this transformation[4]. See Appendix 1 for more information on the Act.

1.1 Strategic commissioning plans

There are 31 integration authorities (IA) across Scotland and the Act places a duty on them to develop a strategic plan for delivering against the nine National Outcomes for Health and Wellbeing[5] and achieve the core aims of integration.

The Scottish Government produced guidance to support IAs in the production of the plans. In essence, the IAs are expected to set out how IAs will plan, commission and/or deliver services for their area over the medium term, using the integrated budgets under their control. The assessed needs of local communities are to be central to planning and

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[1] Scottish Government (2015), *Integration of Health and Social Care Communications Toolkit* http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Material/Toolkit

[2] Hilbert M (2015), Digital Technology and Social Change, Via Wikipedia https://en.wikipedia.org/wiki/Information_Age

[3] NESTA (2015), The NHS in 2030: A people-powered and knowledge-powered health system http://www.nesta.org.uk/publications/nhs-2030-people-powered-and-knowledge-powered-health-system

[4] Scottish Government (2015), *Integration of Health and Social Care Communications Toolkit* http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Material/Toolkit

[5] Scottish Government (2014), National Health and Wellbeing Outcomes, http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes

prioritisation, and sound clinical and care governance processes are to be embedded in the structure and processes. Importantly, stakeholders are to be fully engaged in the production and review of the plans[6].

All IAs published their strategic plans by the first half of 2016 (the list of IAs can be found in Appendix 2).

RCN Scotland wanted to understand what these plans said about the future shape of health and care services. Crucially, they wanted to explore the implications for the nursing profession: the challenges and the opportunities.

1.2 Method
The RCN sourced the plans from those publicly available on websites and selected which papers and appendices were shared with the author on the basis of the thematic criteria set for the review, which were:

1) What the plans tell us about the shape of services
2) What the plans tell us about nursing

An Excel spreadsheet was used for the initial data collection which was subjected to thematic analysis. The main body of this report reflects on the findings of the review and builds a picture of what services might look like in the future. In subsequent sections, the author reflects on the opportunities and challenges for nursing, and sets out some questions for further consideration. First some general observations.

1.3 General Observations
1.3.1 Variability of the plans
The depth and comprehensiveness of the strategic plans varied considerably – though it is important to acknowledge that not every appendix or additional paper from each IA was included in the review. Some plans were pitched at a high level. Several of the plans comprised multiple documents while others seemed to be more akin to a summary.

The size of the plans wasn't necessarily an indicator of content though. The most engaging plans, in the opinion of the author, were those that were inspirational and visionary in creating a clear direction of travel yet practical in setting out how the vision was to be achieved (e.g. Argyle and Bute, Dumfries and Galloway, Dundee, East Lothian, Mid Lothian, South Lanarkshire, Fife and Western Isles).

1.3.2 Reference to nursing
There was little reference to nursing in the majority of plans. However, two plans stood out as bucking this trend. Midlothian and South Lanarkshire contained extensive reference to nursing, giving a clear steer on the implications and expectations of the plan for the workforce (e.g. South Lanarkshire's sections on 'Developing the Workforce' and 'Workforce Adaptability'). Similarly, Midlothian gave practical examples of what needed to happen and by when.

2.   WHAT THE PLANS TELL US ABOUT THE SHAPE OF SERVICES

2.1 Health and Wellbeing Outcomes
There are nine National Health and Wellbeing Outcomes. IAs gave prominence to specific Outcomes based on the strategic needs assessment of their local population. All Outcomes

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[6] Scottish Government 2015, *Strategic Commissioning Plans Guidance* http://www.gov.scot/Publications/2015/12/7436

were referenced to some extent but the majority of the priorities identified related to these three:

Outcome 1	People are able to look after and improve their own health and wellbeing and live in good health for longer
Outcome 2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
Outcome 3	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

See Appendix 3 for a list of the Outcomes and their order of prominence in the IA plans.

A number of other national strategies were referenced. The main ones being the Christie Commission on Public Sector Reform; the Scottish Government's Quality Strategy; 2020 Vision; 'Social services in Scotland: A Shared Vision and Strategy'; 'Same as you/Keys to Life'; 'Building Healthier, Happier Communities', 'Getting it right for Every Child' (GIRFEC) and 'Self-Directed Support: A National Strategy for Scotland'.

2.2 The top five priorities
All IAs included or made reference to a Joint Needs Assessment from which they had identified their priorities for action. They identified anything from 3–14 local strategic priorities with the majority of IAs identifying 7-9. The priorities most frequently referenced were:

- Anticipatory care, early intervention and prevention (including preventing unplanned admission to hospital)
- Recovery and reablement (including facilitating discharge which might otherwise be delayed)
- Personal outcomes-focused care and self-management
- Reducing health inequalities
- Positive experience and support for carers

It was interesting to note how infrequently staff were mentioned in the list of formal priorities identified by IAs, particularly since the transformation of health and social care will only be achieved through active engagement of their staff. This is not to say that the strategic plans did not contain good sections on the workforce; just that engaging staff was rarely identified as an explicit priority.

2.3 How the identified priorities are being addressed
It was not always clear from the plans how the identified priorities were to be addressed. Most of the plans were broad and high level. However, there were some specifics.

2.3.1 Prevention
Most IAs referred to anticipatory care planning, early intervention and supporting self-management. Some segmented activities into primary, secondary, and tertiary level prevention reinforcing the opportunities to promote better health along a continuum. Here are some examples where IAs were more specific:

South Ayrshire cited activities such as 'smoking cessation, sexual health, positive parenting, addressing alcohol abuse and implementing the National Framework for Falls Prevention'.

In addition to these activities, ***Dumfries and Galloway*** are 'tackling loneliness, isolation and poverty' and ***Aberdeenshire*** reflect on their role as 'enabler'.

Renfrewshire are focusing on primary prevention activities such as physical activity options, a single route into web based information and home health monitoring through the 'Technology Enabled Care (TEC)' programme.

West Dunbartonshire are developing a 'social prescribing model' and referred to the 'Link-Up initiative' where older people, carers and local services are working jointly to help older people maintain their independence.

West Lothian have developed a 'risk prediction system' using health and social care data to improve prevention and early intervention.

Midlothian are investing in 'Health and Wellbeing Practitioners, a Public Health Practitioner and two part-time Nurses from the Communities Inequalities Team'.

Shetland highlighted the need to increase capability, capacity and the contribution of non-specialist staff, including the wider workforce through the 'Health Promoting Health Service programme' to embed health improvement in routine practice.

2.3.2 Shifting the balance of care

All IAs identified the need to reduce the demands on hospital based services and shift the focus to primary and community based provision as a foundational imperative. Models of reablement, rehabilitation and recovery were variously referred to. Some built on what had already been tested and others indicated they were introducing new models and ways of working.

Activities included moving to 24/7 working; redesigning pathways of care; developing or extending models of intermediate care; step-up/step-down services and promoting better access to aids and housing adaptions. Indeed, most IAs included a section on the contribution of housing services in enabling people to live at home for as long as possible.

A number of IAs mentioned the 'House of Care' model which supports and enables people living with long term conditions to articulate their needs and decide on their own priorities, through a process of joint decision making, goal setting and action planning[7]. Importantly the model supports staff to embrace self-management.

Here are some of the other activities and initiatives below:

East Lothian are enhancing their 'East Lothian Service for Integrated (ELSIE) Care Team' and developing a 'Recovery Oriented System of Care' (ROISC) in Mental Health Services

Dumfries and Galloway are developing online learning for all staff to support a culture of self-directed support (SDS). Hospital based consultants are working more closely with community teams and the IA are increasing their use of volunteers in supporting people to cope at home.

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[7] Health and Social Care Alliance, Scotland's House of Care http://www.alliance-scotland.org.uk/what-we-do/our-work/primary-care/scotlands-house-of-care/

East Renfrewshire are building on their pilot of 'Family First' workers who support vulnerable families to thrive independently of services. They are also developing models of 'peer support'.

Glasgow have been testing an integrated care project with four GP practices in Govan with community health, social care and the third sector to support and prolong independent living in the community.

East Lothian have a specialist provider framework to support people at home and a more universal 'Help to Live at Home' (HTLAH) framework for older people. They are planning to disinvest in day hospital models and redesign to promote more individual choice. They are also providing palliative care training for care home and home care staff.

Similarly, *Falkirk* are designing community based models of care, based on tested programmes such as 'Closer to Home' and 'Advice Line For You'

Perth and Kinross are developing community nursing teams to care for deteriorating patients to support early intervention in people with long term conditions.

Angus have developed 'Prevention of Admission' teams and *Western Isles* are establishing a health and social care hub in every locality to deliver co-located integrated services. They are developing an intensive re-ablement service which will include for example, GPs providing intravenous diuretics in the community to reduce the number of patients admitted to hospital with heart failure.

2.3.3 Unscheduled care

Most of the IAs are specifically aiming to reduce the number of multiple unplanned visits to hospital and are developing better emergency care pathways.

North Lanarkshire are investing in more intermediate care to reduce reliance on emergency admission and are facilitating early discharge and prevention of admission via AHP re-ablement programmes.

Fife plan to further develop their urgent response service for delivering acute care within the community and *Moray* highlight the need to develop services around the '3 Rs' – Re-ablement, Rehabilitation and Recovery. *East Lothian* are hosting the Lothian Unscheduled Care Service in their Partnership and are 'analysing unscheduled care pathways to provide alternatives to hospital admission'.

Midlothian are providing direct access for people with mental health and wellbeing issues in primary care settings. They also intend to extend the 'enhanced rapid response service' (MERRIT) to cover evenings and weekends.

Angus and *Dundee* are reducing unscheduled care admissions through the scaling up of Enhanced Community Support.

Argyle and Bute are investigating and mapping unscheduled care pathways into local acute services, establishing fast, responsive re-ablement services, and utilising the full capability and capacity of the local NHS, independent and 3rd sector to provide safe and appropriate care locally.

Shetland are streamlining pathways to reduce the reliance on outpatient services and deliver more complex assessments with practitioners in the community. They are also investing in patient education, self-care and self-management and aim to use technology

more to support people at home e.g. telecare, tele-health and are working collaboratively with the third sector to provide services which help people to access services/support in the community.

Western Isles have community unscheduled care nurses working with GPs to reduce overnight admission to hospital'.

2.3.4 'Hospital at Home'

Some of the IAs made specific reference to hospital at home services. Fife IA defined Hospital at Home as 'an alternative to hospital admission and provides the same level of care expected had the person been admitted to hospital'. Others referred to 'advanced care in a person's own home to avoid unplanned admissions to hospital' and to 'facilitate early supported discharge'. Here's a summary of the specific references:

South Lanarkshire are reviewing and enhancing their current model of hospital at home. They are also supporting hospices to reduce bed numbers and deliver more palliative care at home.

Midlothian are investing in a hospital at home service as part of the 'Midlothian Enhanced Rapid Response and Intervention Team' (MERRIT) which is allowing patients to receive advanced-level care within their own home.

West Lothian are reviewing their 'REACT' hospital at home and rehabilitation care pathways to prevent admission and facilitate early supported discharge.

Dundee plan to increase investment in intermediate forms of care, crisis response and home treatment in mental health services.

Fife are exploring Hospital at Home options 'which would include extending into the traditional out of hours period…moving towards availability up to a 24 hour basis'.

2.3.5 The changing role of community hospitals

Some of the narratives pointed to a changing role for community hospitals as services are redesigned:

South Ayrshire are reviewing their operating model to make changes to patient pathways at Biggart Hospital 'in support of rehabilitation and independent living'. They also reference a 'self-management' pilot at Girvan Community Hospital using tele healthcare technology for people with COPD.

In *Aberdeenshire* community hospitals will become resource centres, supporting people to stay at home longer, receive diagnosis and treatment closer to home and, when necessary, inpatient care in their local community.

Clackmannanshire and Stirling plan to develop a 'Community Care Village' on the Stirling Community Hospital site providing a range of health and social care services, training, diagnostics and a purpose built care hub with more than 100 short-stay beds.

East Lothian make reference to developing acute in-patient, day surgery, outpatients, day hospital, diagnostics and joint integrated community services on single community hospital sites.

2.3.6 Discharge management

Effective discharge management was a priority for all IAs. Most made general reference to their work in this regard but there were some specifics:

Perth and Kinross are developing a 'Discharge to Home to Assess' (from acute care) model and are exploring nurse-led discharge and admission.

West Dunbartonshire are aiming 'to identify a cohort of clients/patients at high risk of admission or failure of care packages to proactively develop alternatives to admission'.

Midlothian have a 'Discharge Hub' which provides a single point of contact to support improved discharge arrangements. Consideration is being given to extending an 'in-reach service' to the weekends which will include a District Nurse and Community Care Assistant and, like Perth and Kinross, they are testing a 'discharge to assess' model.

West Lothian are reviewing their 'REACT hospital at home and rehabilitation care pathways' to prevent admission and facilitate early supported discharge.

Orkney have been testing a job role specifically focused on ensuring third sector services are properly taken into account and involved in supporting hospital discharges. Similarly, *Angus* use volunteers to support people return home.

2.3.7 Technology enabled care

The ability to make maximum use of the new technologies to support people to live independently for as long as possible featured in most of the plans. There was a particular focus on supporting people with long term conditions (LTC) (including dementia) in relation to anticipatory care and crisis prevention e.g. falls prevention. Most referred to tele-consulting, home health monitoring and mobile technology to enable staff to be more efficient in a community context and in supporting information sharing:

In addition, *Aberdeenshire* have developed a 'robotic pharmacy kiosk' which enables people to talk to a pharmacist remotely and have their prescriptions dispensed. The new service is designed to improve access to residents who may not have easy access to a pharmacy.

They are also using technology to help people to understand their diagnosis and treatment. During a consultation a patient may miss information if they are unable to take it in. The 'No Delays' programme allows the GP or the specialist to prescribe a 'digital postcard' by email to the patient. This is a personalised package of short videos that explains their condition in detail and informs them about local services.

East Dunbartonshire have secured and equipped a demonstration 'smart flat' which is used to showcase and promote assistive technology solutions.

Western Isles are rolling out a communication system called 'Florence', which uses text messages to guide patients in self-care or motivate them to maintain an agreed lifestyle choice such as diet or smoking reduction.

Despite the focus on increasing the use of technology there was very little reference to what training and support staff might need to maximise the opportunities.

2.4 Hospital services

The Scottish Government guidance states that 'broadly, strategic commissioning will cover, at least, adult primary and community health care and social care, and those aspects of adult hospital care that are most commonly associated with the emergency care pathway'.

Over half the plans (16) clarified the services and functions that were to be included in their IA. This tended to cover adult health and social care community services in line with the

guidance. Most included community hospital and GP beds and mental health inpatient services, where relevant, and a small number had responsibility for criminal justice. In health board areas where there were a number of IAs, one would take responsibility for hosting certain services on behalf of the region. In the case of Dumfries and Galloway, all district general hospital inpatient (scheduled and unscheduled) and outpatient services were explicitly delegated to their IA.

Most of the plans separated the responsibility for operational delivery of hospital services from that of influencing strategic planning such as the emergency pathways more amenable to change when considered system-wide. However, there was generally a lack of clarity as to whether the IA actually operationally managed services such as A&E and emergency medicine.

2.5 Children's Services
According to the Scottish Government guidance, the decision to delegate the responsibility for children's services to IAs is optional.

Excluding Highland who are working to a different model, eleven health boards and councils (37%) had taken the decision to delegate responsibility for both the health and social care components of children's services to IAs. A further six (20%) had delegated certain services e.g. community children's health services or 'universal services' provided by health visitors and school nurses. The remaining thirteen IAs (43%) had no responsibility for children's services.

2.6 Primary care
A small number of IAs made reference to the anticipated new General Medical Services (GMS) contract which will see changes in the delivery of primary care services (due to be published later in 2016). For example, the quality payment system (QOF) will not be part of the new contract and the ambit of primary care will broaden to include the wider primary care team.

Mention was also made to GP practices forming 'clusters' to support an equitable, whole systems approach to service delivery across a geographical area. However, there was little information on what this might entail. Finally, a number of IAs alluded to work they will be undertaking to implement the recommendations from the Sir Lewis Ritchie review of primary care out of hours services.

3. WHAT THE PLANS SAY ABOUT NURSING

The plans were interrogated in relation to the main nursing roles in the community. Nearly all included some reference to nursing (27) but only a few plans included any detail. This wasn't peculiar to nursing; most often the plans were too high level to include more than a passing reference to any professional group.

3.1 District nursing
Just over a third of plans mentioned district nursing (DN). Most of the references were about the responsibility for district nursing being delegated to the IAs. However, there were other references. Here's a summary:

East Renfrewshire, Dundee and *Western Isles* are including DNs in their primary care cluster models. Others speak about DNs being integral to integrated community support teams (*South Lanarkshire, Renfrewshire*)

Aberdeenshire and *South Lanarkshire* highlight recruitment problems, particularly in Band 6 DNs and are redesigning roles in response to changing needs.

Dundee are investing in community nurses to address early intervention and prevention and the 'locality cluster nurse' role is to be developed to prevent unplanned admission and extended to under 65s.

Glasgow City are implementing improvements in community nursing, through workforce development and improving access to community provision. Similarly, **City of Edinburgh** are 'working with other partnerships to conduct a review of community nursing'

Inverclyde are developing a new model of primary care enabling the wider primary care team 'to work to the top of their license' or in the case of nurses at the top of their scope of professional practice, facilitating timely, appropriate treatment by the most suitable professional.

Midlothian are planning to 'increase further the skills of community nurses, including the training and appointment of advanced nurse practitioners (ANPs) who will be able to provide nursing care, which, in the past, has only been available in a hospital setting'.

In **Shetland** five non-doctor islands are staffed by community nurses. They are planning to 'conduct a review of local DN services in line with national *Transforming Nursing Roles* project'. This will involve a review of the skill-set across nursing and care staff leading to the production of a 'nursing in the community' strategy. They also intend to review service provision in remote areas.

Perth and Kinross are transforming community nursing services and are moving towards new models of care and 'outcomes-focused' assessments

Western Isles state that 'redesign will see the integration of home care within the community nursing structure'.

3.2 Health visitors
There was little reference to health visitors (HV). Mostly it was in relation to the universal health visitor pathway and the 'Named Person' requirement for all pre-school age children (e.g. *South Lanarkshire, Inverclyde, Midlothian, Orkney* and *Western Isles).*

In addition *South Lanarkshire, North Lanarkshire* and *Midlothian* emphasised the challenges facing health visiting in relation to recruitment which they thought would be exacerbated should the 'Named Person' requirement come into force.

3.3 Advanced nurse practitioners (ANPs)
A little under a third of IAs made reference to ANPs. Where they did, it was apparent that these roles were seen as fundamental in shifting the balance of care to community settings. For example:

Dumfries & Galloway, Aberdeen City and *Dundee* are developing nursing ANP roles to shift the focus from institutional care to home and community based care.

East Renfrewshire are developing the role of ANPs to provide 'expert clinical leadership to district nursing teams in the management of long term conditions linking closely with GPs'.

South Lanarkshire are 'putting a higher reliance on ANPs in response to an unsustainable medical staffing model'. They see ANPs as integral to the primary care nursing team to build capacity and capability in relation to LTCs and older people. They

also highlight the risk relating to the length of time it can take to train ANPs and emphasise the need to work collaboratively with higher education.

Midlothian see 'scope for strengthening health centres and specialist teams such as MERRIT by recruiting ANPs in supporting a reduction in GP workload'. 'Whilst the direction, implementation and management of this approach needs to be undertaken at a local level' they see that 'there is support for this being progressed initially on a Lothian-wide basis'.

West Lothian are exploring and testing nursing roles in elderly care assessment, specialised discharge, rehabilitation, day hospital and ambulatory care services

Shetland Islands are 'reviewing the skill mix required in the Lerwick Health Centre following the extension of the ANP model, to ensure efficiency and to identify opportunity for savings'. They are also looking at role development for NMAHPs with advanced practice skills in unscheduled care.

Angus make reference to nurse practitioners 'working towards 7 day services'

Western Isles state that in moving to a GP cluster model to provide a more diverse range of services they are drawing on ANPs.

3.4 Support workers

There was some reference to support worker roles to augment the integrated community workforce. These were broader than nursing. For example:

South Lanarkshire and *East Lothian* are developing generic care assistant roles with transferable skills to work across their partnerships. *Orkney* are commissioning a rural generic support worker role and *Shetland* are developing a support worker role in Criminal Justice.

Dundee are investing in personal assistants and care and assessment staff and are increasing their non-traditional health and social care workforce e.g. sport and leisure staff.

Finally, *Fife* highlighted the need for career progression frameworks for generic care assistants.

4. AN EMERGING PICTURE OF SCOTLAND'S HEALTH AND CARE SYSTEM IN TRANSITION

What then will services look like in the next five years or so? In the next section, the author reflects on the collective impact the proposed changes might have, based on key messages in the IA strategic plans.

The emphasis on prevention, self-management with greater choice and control points to fundamental changes in the way in which individuals and communities are supported. Health and social care staff will be joined by others, such as sport and leisure staff, in the efforts to keep people healthy for longer.

> *'The traditional model is no longer fit for purpose. A new paradigm is needed that puts the individual person at the centre, encourages individual responsibility and motivation for change.'* (Clackmannanshire and Stirling)

Technology-enabled home health monitoring will increasingly be the norm and will form the cornerstone of anticipatory care and prevention. More assessments, emergency and intensive care and will be provided 24/7 in people's own homes. Unplanned acute hospital admission will be the last resort, particularly for people with long term conditions.

> *'Transformational change is required to meet Glasgow's projected needs.' (Glasgow City)*

Models such as the House of Care will begin to drive a change in culture from one constrained by organisational norms and expectations to care that is defined by personal outcomes.

> *'(We are) moving to an explicit outcomes focused approach, staff and familial carers will have a strong partnership approach, through clarity of roles and expectations.' (Inverclyde)*

The role of community hospitals will be transformed to that of health and social care resource centres. Diagnostics and treatments previously carried out in acute hospitals will increasingly be delivered in community hospitals and at home or in a homely setting.

> *'Screening & diagnostics will be available in community hospitals and health centres e.g. endoscopy, chronic care management and orthopaedics.' (Aberdeenshire)*

If hospital admission becomes necessary, there will be a wider range of options and settings including day services, intermediate care, step-up and step-down care. These services might be just as likely to be delivered in care homes as in community hospitals. Rehabilitation and re-ablement services will need to expand exponentially.

> *'We will adopt a social model of disability.' (Midlothian)*

For people living in care homes there will be an expectation that the majority of their health care needs will be met 'in-house' thus reducing the need to be transferred to a separate healthcare facility.

> *'A programme of skills development will include the development of nursing home staff to support complex nursing needs e.g. Percutaneous Endoscopic Gastrostomy (PEG) care and Intravenous fluids/medication.' (South Lanarkshire)*

Communities will become more senior- and dementia-friendly and enabling towards people with poor mental health through better information and education. Young families will be supported to provide the best start for children, ensuring anticipatory care and prevention starts at the earliest possible opportunity through 'Universal Services'.

> *'Services are designed and delivered around the needs of service users, their carers and the communities in which they live. Resources are prioritised and allocated collectively by communities' (North Ayrshire)*

The need for coordination of care and services will be greater as provision of health and care services become ever more dispersed across communities, agencies and sectors.

> *'A range of easily accessible information and available support needs to be a key priority to ensure the wellbeing of Carers.' (Scottish Borders)*

The twin drivers of a new GMS contract and the recommendations from the review of primary care out of hours' services will see significant changes in the delivery of primary care

services. The implications of the new contract for GPs and other clinical staff will only be fully recognised on the publication of the new GMS contract.

> *'The next national GP contract ….will enable clinical staff in the wider primary care team - not just GPs but practice and community nurses and AHPs [sic] to work to the top of their license, facilitating timely, appropriate treatment by the most suitable professional.' (Inverclyde)*

5. IMPLICATIONS FOR NURSING

5.1 The opportunities

While the integration of health and social care is likely to be unsettling as the transition progresses, the author reflects on the opportunities for nursing. For example:

- New models in primary care will be developed enabling practice/community nurses to work at the top of their scope of professional practice in urban and remote and rural contexts e.g. advanced practice roles in the community where more intense emergency care will be provided

- There will be greater opportunities for health and care support workers in community settings as part of multi-disciplinary and multi-agency teams supporting improved outcomes for people.

- There is the potential for closer working relationships between different professions and disciplines through joint management arrangements, co-location including hospital and community based teams, joint learning and development opportunities, and shared objectives.

- There will be opportunities to learn from other sectors through exposure to staff from a wider range of backgrounds e.g. community development, housing specialists and sport and leisure

- There is the potential to increase the choice and autonomy of people with health conditions by embracing new technologies e.g. home health monitoring

- The support to develop different, and more enabling, ways of relating with individuals and carers through models such as Personal Outcomes Approach and the House of Care

- Nursing roles in primary care/community and community hospital settings will broaden and diversify

- There is the potential to enhance the image of nursing in care homes as the role and expectations of these services change, which in turn might improve recruitment

5.2 Risks and challenges

Some challenges and risks inevitably accompany opportunities which will need to be overcome. Only six IA plans included formal risk management sections, which we were able to identify in the selected papers, but others identified risks and barriers that have implications for nursing. The main risks they identified were:

- Insufficient capacity in community services; acute wards pushed to limits of capacity because of demand and lack of alternative provision; professional and cultural issues getting in the way of service delivery; staff not adapting and/or are not supported to adopt new ways of working and that organisations and professionals do not gel. In addition supporting people to self-manage their long terms conditions and use Self-Directed Support to its fullest will depend upon all staff embracing a philosophy of working in genuine partnership with service users/patients and carers.

- Supporting people at home will require a continued expansion of 24/7 staffing. Upskilling staff quickly enough to embrace new roles and ways of working and releasing them for training will pose particular challenges. The demand for advanced level nurses is likely to outstrip supply at least in the short term. The availability of suitably qualified staff in care homes due to low wages may also prove problematic in enabling them to step up to intermediate care.

In addition the author identified a number of other risks that were implicit rather than explicit in the narratives.

- Increasing use of volunteers may pose initial governance concerns especially if they undertake activities previously carried out by nurses or other statutory providers e.g. supporting early discharge from hospital. A philosophy of proactive risk enablement will be needed to facilitate the transition.

- Nurses themselves may also find it hard to 'let go' and give space to others to undertake tasks previously within their ambit such as third sector providers, housing colleagues and sport and leisure staff in relation to anticipatory care and prevention.

- Technology enabled care will reduce the burden on nurses. However, not everyone will find it easy to adapt to new technologies in their working lives especially if they have had little previous experience. Indeed it may cause stress and increase the burden of care in the short term. There was little reference to the need for training and development in this regard.

5.3 Nursing leadership and governance
All of these opportunities and challenges will test nurse leadership in every which way. Courageous, visionary leadership will be required to ensure that, at the end of this period of transformation, nursing staff are clear about their unique contribution and are working to their fullest potential.

Most of the IAs strategic plans made some reference to governance and assurance. The plans for **Argyle and Bute**, **West Lothian, Inverclyde** and **Western Isles** were particularly strong in this respect. For example Inverclyde wrote:

> *'Clinical & care governance arrangements are a critical component of the complex integrated environment in which our services operate, encompassing both individual and organisational responsibilities. The core structure of accountability sits in the primary line of general management for services, consolidated by professional lines of accountability through extended arrangements.'*

Nineteen strategic plans had specific reference to senior nurses sitting on integration authorities or being members of strategic planning or advisory groups. This is not to say that the other twelve IAs did not have nursing influence; just that these plans were probably too high level to include reference to any professional group.

5.4 A Note about market facilitation plans
According to the Scottish Government guidance, market facilitation is the process by which strategic commissioners ensure there is sufficient, appropriate range of provision, available at the right price to meet needs and deliver effective outcomes[8]. For example, a commissioning strategy may set out the requirement for care at home provision. The market

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[8] Scottish Government 2015, *Strategic Commissioning Plans Guidance* http://www.gov.scot/Publications/2015/12/7436

facilitation plan allows partner organisations to plan for training and recruiting the necessary staff to provide these services.

Fourteen IAs mention market facilitation but we could only find two that had included finalised market facilitation plans in their strategic commissioning documents. These documents are particularly helpful in creating a compelling vision for what services might look like in the future based on the challenges currently faced by that particular IA. Contributing to these plans might therefore present an important opportunity for nurse leaders to influence the future direction and shape of services.

6. CONCLUSIONS AND QUESTIONS FOR FURTHER CONSIDERATION

This review of the 31 integration authority strategic commissioning plans points to a significant shift in the way services will be provided in the future. Moving from an illness to a wellness service will challenge traditional ways of working. Nurses, and healthcare staff more generally, will increasingly have to work differently with others who also have a contribution to make to population health. Importantly, nurses will need to be clear about their specific contribution in a much changed landscape of provision and co-production.

The transformation suggested in the IA plans create opportunities for nursing but there are challenges and risks to be overcome. From previous RCN Scotland publications, it is apparent that work has already begun in this regard[9].

Some questions are included below that RCN Scotland along with nurses and their leaders may wish to consider in this genesis of a new era for nursing.

1) What additional skills and resources might nurses need to perform specialist functions relating to 'discharge home to assess', the early identification of deteriorating patients and hospital at home models?

2) What further development might nurses need to influence culture change in relation to supporting independent living, self-management and greater choice for service users?

3) Moreover, what system changes might be needed to ensure governance and assurance frameworks do not inadvertently impede progress in supporting self-management, yet still provide robust governance in this complex delivery landscape?

4) What opportunities might there be for nurse leaders to influence closer working between hospital and community services as a result of IAs having input to the strategic planning of emergency hospital care?

5) How might nurse leaders use market facilitation plans to influence the future of nursing across the sectors?

6) What further support might nurses need to enable them to embrace technology enabled care and realise the gains that innovations offer?

7) What might the changes set out in IA plans mean for acute hospital nurses and what further work is needed to facilitate greater cohesion between them and their community counterparts?

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[9] RCN Scotland (2015), Nurse Innovators: Clinical Decision-Making in Action,
http://www.rcn.org.uk/__data/assets/pdf_file/0005/633470/SC0511-Nurse-Innovators-Report.pdf

8) What support might nurses need to work differently with other professionals, volunteers and carers to deliver some services? Similarly what might need to change within the wider system e.g. governance and assurance frameworks?

9) How might nurse leaders develop local plans for nursing development / recruitment / deployment that demonstrate how the profession can support the wider partnership to deliver on priorities and outcomes?

10) How can nurses at all levels ensure their experience and expertise helps to shape the implementation of these plans and the development of the next set of strategic plans?

POLICY CONTEXT

The **Public Bodies (Joint Working) (Scotland) Act 2014** provides the legislative framework for the integration of health and social care services in Scotland.

It requires the local integration of adult health and social care services, with statutory partners (Health Boards and Local Authorities) deciding locally whether to include children's health and social care services, criminal justice social work and housing support services in their integrated arrangements.

Key features of the Act:
National outcomes for health and wellbeing will apply equally to health boards, local authorities and integration authorities.

Health boards and local authorities will be required to establish integrated partnership arrangements. Two models of integration are available for health boards and local authorities to choose from: delegation of functions and resources between health boards and local authorities (lead agency), and delegation of functions and resources by health boards and local authorities to a body corporate (integrated joint board).

An **integrated budget** will be established in each IA to support delivery of integrated functions, which will cover at least adult social care, adult community health care, and aspects of adult hospital care that are most amenable to service redesign in support of prevention and better outcomes.

Integration of health and social care is underpinned by **principles** to improve the wellbeing of service-users and to ensure that those services are planned and provided in ways which:

- Are integrated from the point of view of service-users

- Take account of the particular needs of different service-users

- Takes account of the particular needs of service-users in different parts of the area in which the service is being provided

- Take account of the particular characteristics and circumstances of different service-users

- Respects the rights of service-users

- Take account of the dignity of service-users

- Take account of the participation by service-users in the community in which service-users live

- Protects and improves the safety of service-users

- Improves the quality of the service

- Are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)

- Best anticipates needs and prevents them arising

- Makes the best use of the available facilities, people and other resources

Nine National Health and Wellbeing Outcomes provide a strategic framework for the planning and delivery of health and social care services[10]. The nine outcomes apply across all integrated health and social care services to ensure that health boards, local authorities and integration authorities are clear about their shared priorities, responsibilities and accountabilities for their delivery.

This suite of outcomes focuses on improving the experiences and quality of services for people using those services, carers and their families. In addition people who work in health and social care services should be supported to feel engaged in the work they do and to continuously improve information, support, care and treatment they provide. Combined, the nine outcomes provide a strategic framework for the planning and delivery of health and social care services.

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[10] Scottish Government (2015) National Health and Wellbeing Outcomes Framework, Available online http://www.gov.scot/Publications/2015/02/9966/downloads

LIST OF HEALTH AND SOCIAL CARE PARTNERSHIPS

Health and Social Care Partnership	Linked to NHS Board
1. East Ayrshire	Ayrshire and Arran
2. North Ayrshire	'
3. South Ayrshire	'
4. Scottish Borders	Borders
5. Dumfries & Galloway	Dumfries & Galloway
6. Fife	Fife
7. Stirling & Clackmannanshire	Forth Valley
8. Falkirk	
9. Aberdeen City	Grampian
10. Aberdeenshire	'
11. Moray	'
12. East Dunbartonshire	Greater Glasgow and Clyde
13. East Renfrewshire	'
14. Glasgow City	'
15. Inverclyde	'
16. Renfrewshire	'
17. West Dunbartonshire	'
18. Argyll and Bute	Highland
19. Highland	'
20. North Lanarkshire	Lanarkshire
21. South Lanarkshire	'
22. City of Edinburgh	Lothian
23. East Lothian	'
24. Midlothian	'
25. West Lothian	'
26. Orkney Islands	Orkney
27. Shetland Isles	Shetland
28. Angus	Tayside
29. Dundee	'
30. Perth & Kinross	'
31. Cùram is Slàinte nan eilean	Western Isles

HEALTH AND WELLBEING OUTCOMES IN ORDER OF PROMINANCE IN THE IA STRATEGIC PRIORITIES

	Outcome	Outcome identified as a priority (In order of frequency)
1	People are able to look after and improve their own health and wellbeing and live in good health for longer	1
2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	2
3	People who use health and social care services have positive experiences of those services, and have their dignity respected	5
4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services	3
5	Health and social care services contribute to reducing health inequalities	4
6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being	7*
7	People using health and social care services are safe from harm	7*
8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide	8
9	Resources are used effectively and efficiently in the provision of health and social care services	6

1 = Most frequently identified as a priority
8 = Least often identified as a priority

Note - Outcomes 6 and 7 had equal number of references