


Clackmannanshire and Stirling

Strategic Plan

Staff Engagement Report

2016 - 2019

Health and Social Care Partnership

CONTENTS:

FOREWORD:

Clackmannanshire Council, Stirling Council and NHS Forth Valley are working together in a new way to bring together Health and Social Care services. The purpose is to deliver better outcomes for our service users. Specifically, we want to ensure that people live healthier, longer lives, can be independent and have choice and control, no matter who they are and where they live in the Clackmannanshire and Stirling areas. We are committed to working alongside all our partners in making this vision a reality.

Recognising the critical role of our workforce in determining the success of this approach, we believe that it is essential that our planned approach is appropriately informed, and importantly 'owned', by those who work most closely with our service users, their families and carers and their local communities. To that end, staff across health, Local Authorities, Third and Independent sector organisations came together recently to share views on how services are currently being delivered and their vision, hopes and fears for the changes they wish to see in making integration a reality.

This report summarises what our workforce described as their views of the current picture and their aspirations for the future of Health and Social Care. Participants identified many existing examples of effective collaborative working between different disciplines and agencies which are already contributing to improved outcomes for service users. However, there are also aspects that are not as integrated as we would wish and participants identified several considerations to enable outcomes to be improved further still.

We are strongly committed to making best use of this valuable source of information in further informing our strategies and commitments to plan and deliver services for both, current needs and needs of people in the future. We recognise that this is a first phase of engagement and our ongoing commitment is to continue this dialogue as the process develops. We will ensure that the information captured in this report is shared widely and further resources and initiatives are developed for staff engagement across the partnership.

Shiona Strachan

Chief Officer

Clackmannanshire and Stirling Health and Social Care Partnership

INTRODUCTION:

During May and June 2015, an initial phase of staff engagement on Health and Social Care Integration was undertaken across the Clackmannanshire and Stirling partnership. The purpose of this facilitated face-to-face dialogue was to:

- **'Plant the seed'** in terms of the potential benefits of integration and the changes which might require to be made in order for them to be realised
- Improve understanding of and respect for one another's respective roles within a **workforce for integration**
- **Answer, as fully as possible, any questions** which staff might have and to alleviate any potential anxieties
- **Improve awareness & understanding** of Health & Social Care Integration.

This report outlines key themes from the data collected during interactive workshop part of the sessions, particularly in relation to:

- Participants' views on what the picture looks like 'NOW' for services users, staff and services
- Participants' views on what the picture should look like for the 'FUTURE', to help us achieve the vision for Health and Social Care Integration
- Feedback in relation to staff experiences and perceptions regarding the current period of change and direction of travel.

The purpose of this paper is to inform further discussions in the Partnership in relation to strategic planning and consequently, further phases of staff engagement. It is also intended that key themes of feedback will be shared with staff and the information collected also used to inform the development of a 'toolkit' for staff and managers, to encourage their ongoing engagement in the process for Health and Social Care Integration.

Please note: ***The themes and ideas presented in this report are based solely on the perception of those who participated in the engagement process, either via pre-information for the sessions or during the sessions themselves. As such, the points cited should not be viewed as 'universal', but rather providing a snapshot from which to undertake further, more in-depth analysis and inform strategic planning.***

OVERVIEW OF ENGAGEMENT SESSIONS:

Delivery took place via **8 sessions** across the Clackmannanshire and Stirling area. Each 2.5 hour session included an initial presentation on the Partnership vision for Health and Social Care Integration and our planned approach to-date, followed by individual and table group exercises, focussing on the person at the centre of health and social care services (i.e. **'SAM'**, a typical service user, used as an example). These exercises **aimed at exploring**:

- Examples of good practice and what is working well already, that supports the vision for health and social care integration
- What could be better and some key challenges in achieving the vision
- What the future could look like for 'Sam' on achieving this vision
- What the future could look like for staff and services
- Staff perceptions in relation to the integration agenda and their role in its delivery i.e. individual hopes, fears and expectations for the future of health and social care. (Participants were also asked to take away their own 'pledges' at the end of the session, recognising their individual roles and commitment in making integration a reality.).

The 8 sessions were **attended by 215 participants and facilitators** from across Clackmannanshire and Stirling Councils, NHS Forth Valley, and Third and Independent Sector partner organisations. A breakdown of attendance is as below:

	No.	**%**
Social Services	108	**50.2%**
NHS Forth Valley	50	**23.3%**
Third Sector	26	**12.1%**
Integrated Community Teams	25	**11.6%**
Housing	3	**1.4%**
Independent Sector	1	**0.5%**
University	1	**0.5%**
Council Member	1	**0.5%**
TOTAL	**215**	

Overall, the sessions were well-received, with participants highlighting, for example, that they were taking away ***"a clearer vision of what integration means", "positive thoughts", "a pledge to share information with staff and keep involved fully in process", and "a feeling of being listened to"***.

Examples of comments provided include:

> ***"It was slick, well thought out, one of the best things I have attended in a long time."***
> ***"Well run enjoyable event, well facilitated."***
> ***"Good discussions, everybody included, you did what you said you would, clear tasks."***

Key themes from evaluation from participants highlighting the following:

- They had an improved awareness and understanding of the current state of play and direction of travel in relation to Health and Social Care Integration.

"Good overview of planned changes, gained a much better understanding."
"Reassuring that we all want the same thing – the best for our service users."
"I think I am more convinced it is a good thing for all these changes, as I now know more about it. Session was most helpful."

- They valued the opportunity of multi-disciplinary and multi-agency participation, which facilitated developing understanding of others' roles and recognising shared hopes, fears and expectations.

"Good to speak to others in other departments/services. Good mix of staff, ease of contribution in small groups."
"Alleviated fears, positive opinion on change."
"Clearer understanding of integration services & that we are all anxious regarding change."
"Very engaging, enjoyed sharing views with other professionals."

- The interactive format of the sessions allowed for exploration and sharing of views, while maintaining focus on the person at the centre of Health and Social Care.

"The workshop idea is excellent. Stimulates discussion and enables people to hear ideas thoughts from different services."
"The workshop sessions made you think about people and other needs."
"The layout of the sessions was interesting and informative. Good facilitators!"

- The sessions provided an opportunity for reflection and exploration on 'transitions' and participants' own role and response to change.

"The focus on both individual & organisational change was good."
"I liked being reminded (nicely) of taking ownership of our own thoughts and process of change."
"Not as scary as I first thought."

In terms of **areas for improvement**, when considering future sessions, participants requested that the timings of the session were considered to allow more time for a comfort break and in some cases, for more appropriate venues to be chosen (particularly in relation to acoustics). Some participants also highlighted that while they had found the session useful, they were ***keen to see follow-through on the commitments made,*** particularly in relation to receiving feedback on their contribution and its role in shaping next steps.

WHERE ARE WE NOW?

This section highlights key themes from participants' feedback in relation to:

- What is working well already in terms of integrated working

- What could be better and what are some of the challenges for integration
- What the picture currently looks & feels like for 'SAM' and Services / Staff

What is working well already in terms of integrated working?

In identifying examples of good practice in effective collaborative working, participants highlighted, in the main, their experience was that:

- The workforce across the agencies and organisations is very skilled, doing their best and committed to their jobs.
- A range of examples and stories do exist that highlight positive experiences and outcomes for staff and service users.
- What works well is often due to informal relationships and communication amongst staff across agencies and informal networks and advocacy by individuals (i.e. not necessarily due to formal structures and bureaucracy involved in setting these up).

*The following are **examples of effective collaborative working and integrated services** highlighted:*

1. **Adult Day Services**
   A range of examples of collaborative and multi-disciplinary team-working in delivering the service (e.g. NHS, Dieticians, Physiotherapists, Learning Disability Team, Nurses, Speech and Language etc.) were highlighted for their success in holistically addressing service user's needs and improving their health and well-being.
   "This way of working allows us to provide support whilst gaining insight from a trained professional. This positively impacts on a service user's care, which is the main priority."

2. **Intermediate Care Services and Rapid Response**
   Highlighted specifically for examples of "joined up working and thinking 'on the coal face'", the work of these services was cited as evidence for ensuring smooth transitions between services and tapping into the potential of the various services involved, in meeting outcomes for the service users.

3. **Complex Care**
   Reference was made to effective joint working between social work and the complex care team, in setting up and managing joint packages of support, resulting in good outcomes-focussed care planning.

4. **Single Shared Assessment**
   Reference was made to effective single shared assessment processes operating within some areas (with specific reference to Mental Health and District Nursing services).
   "Completing Single Shared Assessments & Carers' Assessments has enabled Social Services to focus on putting the support package together sooner."

5. **Reablement and REACH**
   - The Reablement Service involves a multi-disciplinary, multi-agency team working in partnership, to transfer older adults from acute hospital beds to a 'halfway to home' environment, prevent admission to hospital / care home and assist older adults to return home. It was highlighted that working alongside other professionals has enabled team members to gain a better understanding of one another's roles, with the team learning to compromise with one another to enable setting of achievable goals for service users, in order to provide the best possible service.
   - The 'Rehab at Home' service, provided jointly by the Homecare 24/7 team and ReACH has improved outcomes for people who are keen to return to their previous level of independence/increase confidence following a period of stay in hospital. The service is described as continuing to evolve as a result of successful partnership working.

   "REACH Rural is successful in that the patients who I have referred have usually had good outcomes, also communication between REACH team and community nursing is very good." (Social Worker)

6. **Care Home Liaison**

   Joint clinics between social work and the care home liaison nurse to prevent hospital admissions, as well as, Short term Assessment Bed Services at Allan Lodge and Beech Gardens were cited as excellent examples of collaborative working.

   "This is most effective, supportive and beneficial to the client group, when palliative care is being given as both services work together providing the best quality care."

7. **Integrated Mental Health Service**
   - The single referral pathway was highlighted for its role in improving pathways to mental health services for service users and ensuring that service users have access to services in a quicker, more effective and more appropriate manner.
   - The development of integrated community mental health teams were mentioned as having supported improved team communication and more effective joint working, particularly as a result of co-location (e.g. Livilands Resource Centre).
   - The benefits of improved information sharing were cited in terms of ensuring that the level of input provided met individuals' care needs, and enabling professionals to prioritise their time more effectively.

   "The development of an integrated mental health services has strengthened existing partnerships between statutory and third sector agencies."

8. **Older People's Mental Health**

   In relation to community Older People's mental health services, reference was made to good communication and information sharing between nursing and social work staff, and in particular to acceptance of others' assessments. Again positive working relationships were described, alongside specific instances of joint working which have supported improved outcomes for service users, such as:
      - conducting joint visits together

- working together to source appropriate care providers
- working together to provide and/or improve packages of care
- assessing risks together and looking at ways to reduce them
- attending case review meetings.

9. Learning Disabilities

The work in Learning Disabilities was cited as providing a great model of integration, with a range of available services, and with service users and carers experiencing less duplication and avoidance of time wastage.

10. Care Programme Approach

The Care Programme approach was mentioned in relation to both learning disabilities and mental health services, as providing a formal system which has helped to facilitate collaborative work. This is described as supporting a shared vision and goals, while maintaining clear professional identity and responsibility within the service user journey.

11. GP Practice Liaison Meetings

Multi-disciplinary, multi-agency GP practice liaison meetings were cited as having helped with more effective communication and information sharing, particularly for those with more complex needs.

12. Discharge

Discharge planning meetings, alongside discharge protocols, allowing good collaborative working between disciplines/agencies, were cited as supporting safe and effective discharge from hospital, whilst at the same time promoting independence (e.g. CCHC Ward 1 Rehab meetings with social work, REACH and ward staff).

"All patients on ward, plans for discharge are discussed; this allows for knowledge to be shared and for all professions to be involved with planning."

13. Anticipatory Care Planning and 'Keep Well' Programme

- The multi-disciplinary, multi-agency approach to anticipatory care planning in some areas was cited as a good example of integrated working.
- The *Clackmannanshire Healthier Lives Programme* was specifically cited as an example of effective work in partnership across Clackmannanshire, as a multi-disciplinary programme offering early intervention and anticipatory approaches.
- The '*Keep Well' programme*, a nurse led primary prevention programme, was also highlighted as an example of multi-disciplinary working to support service users with lifestyle and other social and environmental and psychological support services, as needed and identified by the service user.

14. Tele-healthcare and MECS

- Joint working was described between MECS and health staff, to provide technical solutions to some of the challenges for people with disabilities at home, in care homes and in hospitals.

- The implementation of community falls bundles, and the establishment of a pathway for MECS assessors to directly refer service users who are falling to health colleagues, are cited as good examples of effective joint working.

15. Co-location of Community Care Teams

Staff reported that they valued co-location for multi-disciplinary teams, as this encourages regular liaison and collaborative working. Benefits described include supporting better communication for referrals, encouraging services to ask for advice or signposting, and more effectively identifying/addressing difficulties that require both health and social work input.

16. Joint working between District Nursing and Care at Home

This was cited in terms of enabling and supporting people to remain at home - for example, when District Nurses request a referral for crisis care or ongoing Care at Home support, or when an existing service user has changes to their care needs (e.g. skincare, equipment, palliative care).

17. Joint working with Third Sector, examples of those that are working well include:

- Joint working between Older People's Mental Health Services, Alzheimer Scotland and the Carers Centre providing support for people newly diagnosed with dementia and their carers.
- Joint working with Action in Mind – E.g. Housing, Police, Money & Benefits 'surgeries' have been offered on their premises, enabling service users to access these in a 'safe' environment, that they are comfortable with.
- Stirling Cares Voice (i.e. Stirling Carers Centre's carer engagement group), a group of local unpaid carers, working with local professionals across sectors to ensure that the needs and wishes of carers and the people they care for are taken into account and considered throughout the development of relevant programmes and strategies.

18. Dental Services

- Staff highlighted Dental Action Plan Projects as examples of successful working relationships with Older Adults services / homeless services and Third Sector staff, in taking into consideration what matters to service users and the outcomes they want and expect from the service. E.g. training of care staff in oral hygiene measures for older adults in long term care.
- The Childsmile Programme was also cited as involving close working, effective communication and information sharing with many other health care professionals and educational establishments (e.g. local schools and nurseries) to help improve the children's oral health.

19. Substance Misuse Services

Participants cited that there has been joint working between Substance Misuse Services, Criminal Justice Services and the Voluntary Sector for a number of years, ensuring better communication between professionals, particularly for service users with complex needs.

20. Employability Service

The work of the Employability Service was described as ensuring good partnership working and an integrated approach with NHS for a number of years, including the secondment of an Occupational Therapist to the service, to support service users whose health is a barrier to gaining employment.

21. Performance Measures

Staff mentioned that working groups across health and social care services have been set up in order to agree performance measures, and are realising the benefits of collaborative working e.g. Social Service staff were invited to 'readiness sessions' to share information on the systems being implemented to capture service user information by NHS.

What could be better and what are some of the challenges for integration

Participants described the following characteristics that could be better, as part of the Service Users' and Carers' experience in the current scenario:

- Service Users experience difficulties in accessing the ***right service at the right time***.
- People are asked to ***provide the same information on multiple occasions***.
- ***Transitions from hospital to the community or between services*** can be confusing and challenging due to a lack of coordination and information-sharing.
- Care is ***not consistently person-centred***, i.e. there is need for improvement in terms of how professionals communicate and share information with service users, how effectively they involve service users in decisions and support them to take responsibility and ownership for their needs.

  "Confusing, patchy, not empowered and stressed."
  "Overwhelmed, hopeless, not knowing who to call, lack of own wishes and thoughts being taken into consideration."

Detailed discussion highlighted that there are a number of factors that contribute to cases where one or more of the above characteristics are part of the service user experience. These factors are categorised as follows.

In relation to staff and those who deliver services:

1. Staff are ***unclear as to who to contact and how***. There is a lack of knowledge amongst service providers, as to what services are available, provided by whom and how these can be accessed (or an up-to-date source detailing this information). In particular, participants highlighted the need for better signposting of community-based sources of care and support.

2. Staff are ***not always clear on the roles and responsibilities of others***, or may ***underestimate*** (or indeed overestimate) ***their abilities***.
   "Confusion regarding multiple services & professionals."

3. ***Communication and information sharing*** within and between disciplines and services could be improved – e.g. staff described experiences of an inability or unwillingness to share information, or misunderstandings about what can be shared and with whom or that where information was shared, it was not consistent. Specific mention was made of multiple (rather than shared) assessments and its impact on service user experience.
   "Inconsistency in communication between workers."

In relation to the ways in which services are delivered:

4. ***Care and support is not coordinated and not effectively reviewed***, so as to change, stop or reduce provision where it is no longer needed. ***The lack of a key worker / link person*** is described is a key contributing factor to this. Participants are described this as a challenge particularly when transitioning between services (e.g. from children's services to adult services).
   "It's nobody's job."
   "Needs slip through the loop holes."
   "Information at point of referral about what other services are involved already is missing."
   "Main carer through default ends up managing care."

5. There is a ***lack of consistency,*** with variable availability and quality of services in different locations and for different groups. Particular challenges in ***availability of services out with normal business hours*** were highlighted.
   "No equality of services, time to refer, who to refer to."

6. Services are ***reactive and crisis led***, rather than proactive. To manage capacity, people are moved on when they are not in crisis, or conversely can sometimes escalate into crisis when there isn't enough capacity to see to them in a timely manner, reducing our ability to deliver more sustainable outcomes.
   "We should deal with long term and not just 'fix it' or 'quick fix'."
   "Identify issues/risks prior to crisis point, e.g. hospital admissions."

7. There are difficulties with ***referral processes*** (including referrals to and from Third Sector organisations) – particularly linked to communication and information sharing challenges highlighted earlier.
   "Different routes of referral."
   "Reliance on care providers to make contact."

8. ***Transitions from hospital to the community*** can be without effective planning and coordination, including communication with community-based staff, resulting in discharge going wrong.
   "Shortages of packages of care available can hold up discharge."
   "Initial transfer of care but ongoing planning & co-ordination dissolves."

9. ***Connections with communities and with the Third and Independent Sector are not sufficiently effective*** to ensure that people are well supported in the community, particularly

where NHS and Council services withdraw. This can also result in avoidable deterioration in physical and mental health and wellbeing, as a result of social isolation.
"Communication from hospital to 3rd sector before discharge (could be better)."

10. There is ***need for improvement in relation to carers***, both in terms of ensuring that they are appropriately informed and involved as partners in care, but also in terms of ensuring that their own needs are appropriately met and in a timely manner.

In relation to resources and the 'whole system':

11. ***IT systems*** don't talk to one another, to enable effective information-sharing and seamless transition between services. This was consistently highlighted as one of the biggest barriers to effective integrated working.
"We all use different IT systems and they do not interact with each other."

12. There is a ***lack of overall coordination***, between and within disciplines and agencies, resulting in ***significant inefficiencies and fragmented care***. It was specifically highlighted that, there can be ***too many people involved*** and ***duplication*** between roles and services***.***

13. ***Bureaucracy and red tape*** was described as a barrier in delivery of seamless services.
"Too many procedures to put resources/services (required) in situ."
"Delays due to paperwork being processed."
"Processes are prohibitive, too many processes & systems."

14. ***Staff described that they perceive there is insufficient resource and capacity*** within services to meet demand. This is described as having been further exacerbated due to the financial pressures in the public sector.
"Being truly person centred is prohibited by time/resource constraints."

15. There are ***continuous and often significant changes*** underway and these are not always effectively managed. The culture could ideally be ***more focussed on transformation*** and ***being less risk averse***.

16. ***Workforce issues,*** such as recruitment challenges in some areas e.g. posts unfilled and covered by temporary staff); inconsistency in pay and staffing across the public sector and its impact on job satisfaction; varied cultures and a lack of awareness and understanding of these; were also raised as having an impact on care.

17. There are ***challenges in relation to transport and housing*** and the availability of services and appropriate equipment within the community to support people to live at home.

18. There is a need to ***manage public expectations*** and create more awareness / signposting of the various services, what they offer and crucially, what they don't offer.

What the picture currently looks & feels like for 'SAM' and services / staff

In summary, participants described the current ('NOW') picture in the following ways:

For 'SAM':

- ***"Confused"***
- ***"Being passed from one service to another"***
- ***" 'Nice lady with uniform comes to visit, don't know who she is' "***
- ***"Fragmented"***
- ***"Frustrated"***
- ***"Lonely, anxious, demoralised, lots of people to remember"***
- ***"Overwhelmed"***
- ***"'Roll of a dice' on how it's going"***
- ***"Disempowered"***
- ***"Anxious"***
- ***"Isolated"***

For Services / Staff:

- ***"Flashes of Brilliance"***
- ***"Want it to work but scared that it does not"***
- ***"Inefficient"***
- ***"Pressurised"***
- ***"Unclear"***
- ***"Disjointed / disorganised"***
- ***"Overwhelmed"***

WHERE DO WE WANT TO BE?

Aspirations for the future of 'SAM'

Keeping SAM at the centre, participants described the following as their aspirations for what an 'integrated future' might look like:

1. Sam receives ***high-quality, holistic, person-centred, outcomes-focussed*** care, *which* ***meets his individual needs***. When accessed, care is ***effectively coordinated and streamlined*** to ensure that it is seamless for Sam, even when transitioning between services.
   "Seamless. Less stressful. Outcomes being achieved."
   "More streamlined, more confidence in the services provided."
   "Won't have to repeat himself."
   "The service wrapping around the person, not the other way round."

2. Sam has a ***named care coordinator*** (or single point of contact), who he has chosen and who 'facilitates' his care and support on his behalf, being able ensure timely access to appropriate services.
   "Sam would know who to call and talk to."

"Has a single point of contact with regular reviews."

3. When Sam requires ***access*** to services, he can do so ***easily and quickly, knowing where to go*** for help. This is supported through, for example, availability of relevant and appropriate ***7-day services***, which operate ***beyond business hours; single points of access / referral*** and being able to re-access appropriate services after discharge.
   "Sam can access the right service at the right time"
   "Doesn't have to wait until a crisis happens to get help."
   "Sam is more in control. Navigation of services is easy."

4. Sam is ***well- informed***, has a clear understanding of ***what he can expect and from whom,*** and is able to see all of the information he wishes. There are ***regular meetings*** involving Sam, his carer and key people involved in his care, during which he is ***listened to and involved*** in decisions. Moreover he is in control, having ***choice and ownership*** of his care (e.g. through self-directed support), including ***where and when it is provided***.
   "Two-way conversation - ask Sam what he wants."
   "Sam is actively engaged."
   "Sam has a say in his own care."
   "Sam is empowered."
   "Sam has the information to make decisions about what he needs."

5. Sam has an ***integrated, single, shared care plan***, which is ***regularly reviewed***, and which is also ***anticipatory*** in nature. This plan is ***flexible*** enough to respond where his needs change, and ensuring that ***outcomes are shared***, even when Sam loses capacity.
   "Able to plan for the future."

6. Those providing care and support ***proactively identify any change*** in Sam's condition and ensure ***early intervention,*** avoiding the need for a subsequent crisis response.
   "Having a life – not always dealing with a crisis."

7. Sam is ***able to stay at home***, rather than have to go into hospital. This is supported through improved availability and use of ***assets within his community***.
   "At ease – Living the life he wants – Feels supported."
   "Less isolated. Makes use of all available resources."
   "Involved in social activities and social groups."

8. Sam is ***supported to self-manage***, through education and awareness-raising. This is balanced by ensuring that he knows who to contact/where to go, should he need help. ***Technology solutions*** are in place which enables Sam to be more independent, by providing care closer to home.
   "Sam is taking on responsibilities for his care"
   "Right balance for Sam."

"Sam has control back."

9. There are ***fewer unnecessary intrusions*** in Sam's life by staff, with fewer people involved and consistent faces that he knows, and a frequency of their involvement matched to his needs.

10. With less pressure in hospital and no delays to discharge, there is ***ease of access to a bed*** when Sam does require ***acute*** care and effective joint planning takes place to ensure a ***smooth, safe and timely discharge***. ***Rehabilitation and reablement*** services are in place which help Sam to remain at home, or to return home quickly, but safely following a period in hospital.

11. Sam's ***carer*** is recognised as a ***key partner*** in his care. They are themselves ***well-supported***, their own needs having been assessed and met in a timely manner, for example, being able to access the Carers Centre or have planned respite in place where needed.
    "Families know where to go to for help at an early stage."
    "Partner is well-supported. (less like carer and more like partner again)."
    "Regular respite for the carer."

Aspirations for the future of staff and services

To enable this vision of an 'integrated future', participants described their aspirations for where we would like to be, in relation to staff, services, resources and the 'whole system' with reference to these key areas:

1. There is a ***multi-disciplinary, multi-agency team*** approach to meeting service users' needs (which includes the third and independent sector). Where possible, the teams are ***co-located***. They have a ***shared vision*** of working together to keep people at home, for which they are ***jointly responsible*** and demonstrate ***shared values*** in their approach. ***Services across the public, third and independent sectors*** are effectively integrated and working in partnership.
    "Information sharing with good clinical governance."
    "Acknowledging that colleagues 'talking' is worthwhile."
    "Removing service focus and looking at what people want to achieve and how to help that happen."

2. **Communication** between all staff is ***easier and better***, with ***consistent, up-to-date sharing of information***, which is written in a language that is meaningful to all. This includes ***single shared assessment*** processes, which remove duplication for staff and service users. Specifically, there is improved ***communication between acute and community based services*** upon admission and discharge.
    "***Right people know the right information at the right time."***
    "Everyone knows what is important to Sam. Working together, shared information, more co-ordinated, less duplication."

"'Singing from the same hymn sheet'."

3. Team members are ***clear*** regarding their own, and their colleagues', ***roles***. There are both ***core and shared*** roles, which ensure that the right person is doing the right thing at the right time for the service user. Team members ***trust and respect*** one another as ***equal partners***, ensuring positive relationships and 'true' partnership working. There is no room for risk aversion or for blame. Instead, the team ***learn from each other*** and think together to bring about ***creative solutions***.
   "Staff are empowered – they know their role and remit, they use initiative."
   "Staff have a sense of achieving Sam's expectations."

4. Staff describe an aspiration for ***well-managed resources and capacity***, which will further allow them to spend sufficient time with, and focussed on, the service user. They perceive that in such a scenario, they are able to ***access training and development opportunities***, and ***feel there is equity and fairness of pay across the system.***
   "Resources and funding are more appropriately allocated."
   "Resources are more efficiently and effectively used."

5. ***Staff*** are more ***engaged and motivated***, experiencing lower levels of stress and sickness absence. This includes having ***increased morale*** and ***improved job satisfaction***. They described a desire to be feeling more confident and supported in their roles, feeling valued and listened to, and experiencing improved health and wellbeing themselves.

6. ***Systems*** are simple and ***clear***, user-friendly and ***easy to navigate***. There is ***improved efficiency and less duplication*** through e.g. portable devices, electronic recording of data etc.

7. ***Efficient, easy to use, integrated IT systems*** are in place, which all services can access and update, enabling ease of information sharing and more efficient use of staff time. Where possible, staff are able to access and update these systems from ***mobile devices*** in the community.

What the picture would look & feel like for 'SAM' and Services / Staff

In summary, participants described their aspirational picture for the 'FUTURE' as follows:

For 'SAM':

- ***"Better outcomes for service users across the range of services."***
- ***"More streamlined care, right person, right place."***
- ***"Better outcomes for patients, better health, more independence."***

For Services / Staff:

- ***"Excellent service delivery that always meets individuals' needs."***
- ***"To move forward with better and improved care for the service user."***

- *"Things are better for everyone."*

WHAT ARE STAFF PERCEPTIONS – FEARS AND HOPES?

Prior to attending the engagement events, participants were asked to provide a list of three words that first come to mind, in relation to Health and Social Care integration. Their responses are presented here using a 'Wordle'. This graphical representation includes the words provided, with the size of the word being indicative of the frequency with which the word was used i.e. the larger the word, the more frequently it was used.

Fears and potential barriers to success:

In relation to outcomes and impact:

1. A number of participants expressed fears in relation to uncertainty about what the future will look like, and specific worries about potential ***reduction in staff numbers, job losses, dilution of skills / loss of professional identity,*** changes to ***terms and conditions*** of employment and increased ***workloads***.
   "[I fear that] jobs may be lost or change greatly."
   "[There will be] loss of identity and dilution of clear roles."
   "[I fear] loss of employment /service and lack of job security."

2. A significant fear expressed amongst participants was ***that 'integration' doesn't work***, and fails to deliver or it ***may even be disingenuous***. Unrealistic expectations, the vision being 'lost in translation', politics and power influences were cited as reasons for these concerns.
   "Nothing will change."
   "Things won't necessarily get better."
   "Too big to do well."
   "Too much focus on politics and power."
   "Just a cost cutting exercise."
   "Gaps in communication at all levels, will affect care and staff morale."
   "[I fear that] this is a lip service exercise."
   "Another piece of legislation creating additional reporting."

3. Concerns were expressed on the ***'real impact'*** of the changes ***to service users and their carers,*** and whether ***things would in fact, get worse for them*** as a result of changes. It is feared that integration (particularly during the transition period) will lead to ***even more people being involved in providing care,*** increased ***confusion over roles, and greater difficulties in communication*** within and between services. As a consequence, there were concerns expressed over ***greater confusion for services users*** who, being unsure of who to contact, will end up feeling isolated or just 'go to A & E anyway'.
   "Too much bureaucracy that creates negative outcomes for service users."
   "I fear there will be little change to clients' experience."
   "[I fear] that some people slip through the system and don't get the support they deserve."
   "[I fear] that carers will not be seen and treated as equal partners in care."
   "Breakdowns in communication may hinder the process."
   "[I fear] that services get more complicated & harder to navigate than before, or that there are fewer services available."

   Participants also expressed concerns around the challenge of ***creating single care co-ordinator*** roles. Some questioned its merit, whilst others questioned who would undertake

such a role i.e. whether it would be a standalone role or, if not, how effectively it could be undertaken as part of existing substantive roles.

4. Participants highlighted a fear of ***integration being service-led*** (rather than outcomes-focussed), resulting in ***what is already working well being lost*** or ***inequity in the partnership***. There was recognition of the challenge of ***moving*** from a reactive, crisis-led service ***to a proactive one***.
   "I fear that it becomes 'top heavy' exercise and does not filter down to practice level."
   "[I fear] some services being lost in the mix."
   "[I fear] changes to non-core services due to budget constraints."
   "The needs of a person might outweigh what a service can deliver."
   "[I fear] that we won't be brave or radical enough to achieve the changes we need to make."
   "We have excellent working relations with other agencies, these have been fostered over many years and are threatened by changes in working practices."

5. In relation to the ***third and independent sector,*** there was recognition of current ***sustainability*** challenges, as well as a fear that their ***voices*** (and that of individual third and independent sector organisations) would not be ***not be heard or understood***.
   "[I fear] recognition is not given to third sector services."
   "[I fear] reduced funding to third sector services."

6. People cited the challenge of being able to ***manage public expectations*** (e.g. reducing dependency on services, improving self-management), and a fear of ***increased, unrealistic expectations from the public***, which would ***create even greater pressure*** on already overstretched services.
   "Front line staff will once again be left to explain to clients/patients why promises are not being kept."

In relation to the change process:

Participants expressed the following concerns regarding the change process, as **potential barriers to the success** of health and social care integration:

7. It would be ***difficult to implement*** and ***take a lot of effort*** i.e. it won't be a smooth transition and there will be some ***chaos and confusion, teething problems and errors***. Staff were also concerned about ***not being sufficiently involved*** in the process.
   "Another change that is poorly managed with little communication and consultation."
   "Overly complicated."
   "Problems changing culture and postponed views of different authorities, leads to delays."
   "It will take a long, long time."
   "Time frames will continue to be poor."
   "I fear there will be too much effort put into developing plans and not enough in implementing them."

"[I fear] 'Chinese whispers' breeding negativity."
"[I fear] that staff become so stressed an anxious about potential changes, it impacts on service users and their outcomes."

8. There would be challenges in ***overcoming existing cultural barriers*** (e.g. 'professional preciousness', silo working, relationships between disciplines / agencies etc.), with people finding it ***difficult or being unwilling to change***. There could also be ***conflict and disagreement*** between disciplines / agencies, or that ***personal agendas get in the way***, which stall progress.
   "It requires a huge shift in culture and way of working."
   "[I fear] clashes in professional values."
   "So many professional backgrounds coming together – there will be difficulties coming to a consensus /agreement."
   "Some people can't let go of the past and embrace power/ resource sharing."
   "I fear health and social care don't understand each other enough at present and there'll be gaps in service in the future."
   "[I fear] services will say 'that is not our responsibility that is another service'."

9. Staff expressed concerns that they perceive ***funding and resources*** (including staff) may be ***insufficient*** to make the change happen, considering existing capacity challenges and financial pressures in the public sector. This included a recognition of current ***recruitment and retention difficulties*** (and recognising the impact of an ageing workforce).
   "Financial constraints may prevent individuals being outcome focused and return to a service led approach."
   "Will there be enough funding & staff?"

Hopes and potential enablers to success:

In considering the vision for integration of health and social care, participants were also asked to express their hopes and expectations in making this a reality. Although several key themes in relation to this have been captured under the '*Where do we want to be?*' section of this report, the points below provide a summary of what staff highlighted as being important to them in realising the vision.

Significantly, participants expressed acknowledgement of the importance of the vision and their key desire that ***"integration works"***. This was described as bringing change for the better by ***making a real difference*** to those who use services and their carers; i.e. they receive the care and support that they need to achieve ***better outcomes*****.**
"My hope would be that Health & Social Care Integration lives up to its vision."
"[I hope that] things are better for everyone."

"[I hope that], with integration potential is maximised and services will be person centred and make changes to lives."

In identifying their examples of 'SAM', some groups also highlighted that it was crucial to remember ***this wasn't just about 'older people'*** i.e. it was recognised that integration impacts a range of people across a range of services (e.g. a young adult transitioning from Children's services to Adult Services).

Participants expressed hopes in relation to the ***opportunities*** within the health and social integration, and its ***potential to bring about changes and improvements*** not only for service users, but also staff and the ways is which services are delivered.
"Seamless care delivery to all individuals both identified and those not on the systems!"
"I hope that people take it on board and use a positive attitude towards it."
"[I hope that] integration is seen as a great opportunity by all partners."

Participants also cited the following, as potential **enablers to a smooth transition and effective execution** of health and social care integration:

1. The process is ***well-led***, with ***focus on our vision and outcomes*** throughout.
   "[I hope we] keep a focus on delivery not get distracted by politics, bureaucracy."
   "It can work with all working together and when people have an understanding of what the possibilities may be."

2. There is a ***clear plan and effective structures*** in place to facilitate the process. Participants expressed hopes for the process to not take too long, and equally not be too rushed.
   "[I hope that there are] clear explanations of how integration will be put into practice."

3. The process is subject to ***regular review*** and there is timely identification and ***resolution of difficulties***.
   "[I hope] it will work, that we can STOP just changing things and really make it happen!"

4. There is ***regular and informative communication*** to ***manage expectations*** update on progress (both staff and the general public). Staff expressed a desire to have ***sufficient opportunity to influence*** the shape and direction of the process.
   "[I hope that] our views are listened to by people in higher positions."
   "[I hope that] staff morale and engagement is improved."

5. Efforts are made to learn from, sustain and spread ***what is already working well***.

6. ***Everyone takes responsibility*** to make it work, with particular references made to support and commitment required from leaders and managers.