But we’ve always worked like that haven’t we?

Learning from the staff experience of transition to an integrated community support team in East Kilbride and Strathaven

Report by David Strathearn – Independent Organisational Development Consultant
INTEGRATED COMMUNITY SUPPORT TEAM IN EAST KILBRIDE AND STRATHAVEN

Learning from the staff experience of transition to an integrated team

Report by David Strathearn – March 2014

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1 Introduction and Project Outline

The Pilot Evaluation report of the Integrated Community Support Team (ICST) in July 2013 states that, “the impact of ICST cannot be immediate since the model, while building on existing positive work in the locality, demands a fundamental shift in culture, processes and practice”.

This evaluation project was to investigate the workforce development factors that have contributed to improved collaboration, responsiveness and flexible working across ICST, as well as to identify the limitations and barriers within the existing model.

The evaluation process involved meeting with people working in or around the team to try and identify what, if anything, has changed in the practice, behaviours and attitudes of staff and what contribution this may have made to the improved outcomes for the people supported by the team.

A series of meetings was held with staff to hear about staff experiences of the integration process. The first groups comprised a mix of frontline staff working across the whole ICST area. This provided important perceptions of change. The next stage was to put these perceptions to a group of Team Leaders in a separate meeting. Finally, in order to ‘capture’ a view from a voluntary sector partner associated with the team, a meeting was also held with the Carer Resource Development Officer of South Lanarkshire Carers Network Ltd.

2 Meetings with Staff

Frontline - Discussions were held with four groups of between four and six staff. Each group comprised a mixture of NHS and Local Authority staff. In total, 20 people took part in the discussions, 13 from NHS Lanarkshire and 7 from South Lanarkshire Council. The NHS staff members came in equal numbers from each of the three team locations, Greenhills, Hunter and Strathaven, with one member of the overnight team also present.

A cross-section of 11 job roles was represented including nurses, occupational therapists (health and social work), home care manager, physiotherapist, support workers and administrator. (See Table 1 in the acknowledgements section for full breakdown of staff in discussion groups).

Each discussion lasted around an hour and a half and was led using a series of prompter questions. The questions (see Appendix 1) were designed to try and determine any correlation between the improved outcomes for service users, carers and the organisation claimed in earlier evaluations of the ICST¹.

A key policy driver behind the creation of the ICST has been the emerging Public Bodies (Joint Working) (Scotland) Act. This was passed for Royal Assent in April 2014, with associated guidance expected to be complete in late 2014. All integration arrangements are to be in place by April 2016. It is, therefore, most relevant to set the questions asked of the team against the outcomes relating to Integration. Most briefly described these are:

Outcomes for:

Service Users – Healthier Living, Independent living, Positive Outcomes and Experiences and Safe

Carers – Carers are supported, have Positive Outcomes and Experiences and are Safe

¹ Hearty M. Pilot Evaluation Report; July 2013 and Sinclair A. Measuring the success of the Integrated Community Support Team and ICST Staff Focus Group Summary.
**Organisation – Effective Resource Use**

**The Workforce – Engaged workforce**

The researcher was particularly keen to find out if there had been any conscious shift to a more outcomes-focussed way of working and if the approach to determining care and support was one of collaboration between users, carers, health and social services. In other words, if the development of an integrated team had deliberately embedded a different way of working, or if the changes were more around structures, communications and resources.

Another key area for examination was the extent to which the workforce feels engaged. In the words of the Short Life Working Group on Integration, feeding into the Joint Working Bill, ‘Engaged Workforce’ means that: “People who work in health and social care services are positive about their role and supported to improve the care and treatment they provide.” The researcher was keen to pick up on the impact of any attempts to improve engagement with the workforce and whether there was an awareness of any links between improved engagement and improved outcomes for the users and carers being supported.

**Team Leaders –** Learning from the experiences and picking up on the points raised at the four meetings with teams, a series of questions was prepared for a meeting with team leaders (See appendix 2).

**Carers Support –** A one to one meeting was held with the Carers Support Development Officer of South Lanarkshire Carers Network. A less structured approach was taken to this meeting, which took the form of reflecting on the findings to that point. However, the meetings with the ICST teams and leaders has not given much insight into changes or challenges which might have impacted on outcomes for carers and so the meeting was, naturally, primarily focussed on this area.

**3 Recording the Conversations**

In an effort to allow interpretation of the responses from the meetings with the mixed groups of frontline staff, four headings have been adopted under which to record the changes or the challenges that staff had undergone or experienced as a result of the integration process. These are:

- Leadership
- Learning and Development
- Skills
- Other Enabling factors and Attributes

The notes from the four conversations have been combined in a table (Appendix 3) using these headings above and set against the outcomes for the different groups (Service Users, Carers, The Workforce and Organisational).

Comments from the Carer Resource Development Officer have been added (in green text) to this table, as she filled in valuable gaps in the ‘picture’, relating to outcomes for carers. It is interesting to note that staff would have almost certainly been aware of the fairly significant learning and skills development that has been undertaken by them in relation to carers, but it was not sufficiently high in their consciousness to bring up in the meeting.

The responses from Team Leaders have simply been noted against the questions asked of them (See Appendix 2.)
4 Changes in Practice, Behaviours and Attitudes

Drawing from the notes of all the various conversations, a number of themes emerge around what has changed for this staff team, as well as what would be seen as desirable change associated with integration. The latter is particularly important, as there are potential lessons for future integration projects as well as for the future development of the ICST.

4.1 Leadership

The questions sought to determine if there had been changes in the leadership approach in the integrated setting – both ‘top down’, as well as at lower levels in terms of greater scope to lead.

People generally felt the greater range of resources available to them enabled them to better direct and contribute to support/care plans. There were two ‘camps’ when it came to commenting on whether integration had ‘freed up’ and given more autonomy to lead within a wider sphere of operation. Some people felt more confident to work across professional boundaries, mainly because they had become more familiar with each other’s roles. Others felt that integration had led to more restrictive complex processes with more paperwork.

Assessment work is still done separately according to separate professional and employer organisation lines. This may be unavoidable, but the inability to easily share information electronically between health and social work was regularly brought up as a restriction to integration. It appears that the process of integration for the ICST is one which was started in health, achieving better co-ordination, then radiated out to social work and is now beginning to move to encompass other third and independent sector organisations. As a consequence, old systems have been imported into the ICST, with a view to integrating them over time rather than ‘launching’ with a new system from the start. It may however prove difficult for the service’s senior leaders to separate these different ‘lines’ at a later date.

It was notable that there was a very varied appreciation of the value of monthly Practitioner Group meetings. There had been a plan developed for practitioner meetings earlier in the establishment of the ICST, however the team members consulted did not reflect the notion of an overall team plan when discussing these meetings, which varied in frequency and composition of attendees depending on location. Nevertheless, in general, practitioner meetings were seen as representing good opportunity for sharing knowledge across health disciplines, Home Care and the Social Work OT’s, but were currently less engaged with by Social Workers. These meetings also have the potential for leadership to be demonstrated which achieves consistent approaches and drives the whole integrated set up. Team leaders recognised the need to restructure these meetings, increase the emphasis on practice development, rather than case review, and better align the sub teams within the ICST to the various geographical areas (the exception being Strathaven, which seemed to be functioning particularly well). However, they did not feel particularly able to influence change to this effect.

Interestingly, it was reported that to function well, these meetings required a flexible approach to leadership, as the professional lead role requires to shift depending on the support needs of the person being discussed.

All discussion groups commented that the role of the ICST is not properly understood by the staff in the hospital who are referring people into the team. This view was re-enforced by the team leaders. This must surely be an issue for leaders of the service going forward (or designers of future services
who can ask, ‘how will a seamless approach be achieved?’ and, ‘can the hospital be more involved in the development process so that staff there better understand the new service?’

A positive aspect of leadership has been the top down support given to engaging the voluntary sector. Whilst the voluntary sector does not yet carry out a direct role in helping shape support plans at their inception, it was clear that engagement with the voluntary sector is being encouraged, widening the sphere of support available to the people being supported by the team. Most notably, the Carer Resource Development Officer said that she felt the positive approach shown by senior leaders towards her organisation has opened doors and given a “stamp of approval” to carer support, which now has an extensive presence across the ICST catchment.

4.2 Learning and Development

The creation of the ICST was not accompanied by much formal learning and development. One exception has been the Supporting Your Independence training (SYI), rolled out to all Home Carers and, more recently, some personal outcomes training has been rolled out through Social Work, but has not yet been extended to the full ICST staff group. Both of these training programmes are examples of initiatives driven by the Reshaping Care for Older People agenda (RCOP), rather than being instigated specifically for the benefit of ICST. Since RCOP can be seen as the precursor (or even pilot) to the wider integration agenda, it would make sense to spread the associated training throughout the whole team.

Some nursing staff commented on having done outcomes training prior to the establishment of the ICST, but there was not a strong sense of association between the training and the functioning of the new service. The shift to a personal outcomes focus goes hand-in-hand with integration and is of course highly relevant to the work of the team. Perhaps a stage missing was simply to get the newly forming team together to really concentrate on what training and experience they had which they could best apply to influence and inform a new way of integrated working. This is something any team forming in the future could easily do.

So, if an opportunity to do more preparatory training was missed here, it may be because it is a real challenge to cover all the bases when integrating from a ‘rolling start’. As one manager put it, “The perils of not starting everything from scratch, but amalgamating from all points”. Integrated working frequently requires a shift in approach and attitude and whilst it might be assumed that all the health and social work professionals have the requisite knowledge and attributes, probably the most important thing is to develop a shared approach – in particular around how to put the service user and carer’s personal outcomes at the centre of a collaborative service. This sounds obvious, but considerable attention and energy appears to have been diverted and focussed on dealing with the upsets and disruption caused by structural change and organisational differences.

Subsequent to the research being conducted it has been pointed out by one of the senior managers that there had also been individually focussed development work carried out, through support and supervision, to enable the integration process, but the group interview format of this investigation didn’t lend itself to people revealing much about their personal development and challenges, although some were still remarkably candid!

Considerable effort was put into building knowledge and awareness of the different professions involved in the team through a series of team building/change management sessions. Commonly referred to as the ‘getting to know you’ sessions, these events were generally seen as useful, although for some reason the more structured approach of the initial session seems to have been less well received. Over the conversations with staff it became apparent that apart from the 24/7
nature of the service and its orientation around distinct localities, the most powerful driver for the improved outcomes being delivered by the team was simply the improved inter-personal and inter-professional relations that had been developed. This cannot be underestimated. Time and again, staff reflected on their improved understanding of each other’s roles, which in turn improved their confidence to act. Service designers of the future should take note and invest heavily in enabling people to get to know each other!

Looking forward, the team leaders emphasised the need for ‘getting to know you’ to be embedded into induction processes. Visits to meet colleagues in different parts of the team does occur at induction, but it was felt there was more scope for formalising joint induction processes.

Another significant area of learning and development, but one which was not particularly recognised by staff team members as being associated with integration, has been the establishment of Carer Champions in GP practices and other settings. Having staff around who can act as a conduit to cares support and maintain the profile of carers’ rights can actually be seen as integrated practice in action.

4.3 Skills

The groups did not report on having to acquire new technical skills as the team integrated, although it was pointed out that prioritisation/triage skills clearly have to be used more, as referrals range greatly in complexity and levels of support and co-operation required.

It was the ‘softer’ people skills that staff felt they used more now to maintain relationships across the team. Where two or more professionals were working with the same person, the ability to know when to step back from asserting a judgement and to be more accepting of others assessment were seen as important qualities, if not actual skills.

A management skill that was required for integration, was that of a manager (and the person being managed) being prepared to operate under different lines of professional accountability. In other words, situations where a person is managed by a someone from a professional discipline other than their own, but still retaining professional support and supervision within their own profession. The need for preparation for this scenario on ‘both sides’ was not fully considered by at least some leaders ahead of integration. There may well be a lesson here for those creating implementation plans for integration in the future.

4.4 Other Enabling Factors and Attributes

Much of the discussion about what else had changed to enable better outcomes centred on the structural changes. So, the move to a 24-hour service, access to resources (where they were not constrained by budgets, e.g. equipment, aids, etc. or technology) were seen as positive. However, this investigation was less concerned to determine structural and resource changes and more about the changes that the staff have undergone or experiences as the team became integrated.

The main, and very significant, enabling factor is the speed and efficiency of communications being achieved by knowing each other better, being co-located (many felt that further co-location of social work staff would further improve this situation) and being confident to ‘pick up the phone’ to each other.

A hugely ‘disabling’ factor around communications was reported by some team leaders when reflecting upon the mixed messaging around the integration process, which flowed down respective organisational lines in the early days of integration. It was reported by one team leader that she felt
that the stress that this caused deflected attention from supporting patients. Based on this, any effort that can go into agreeing joint communication strategies ahead of future integration projects will almost certainly pay off.

There were some other disabling factors reported, mainly around the incompatibility of IT systems and shortage of Home Carers. Not only was this shortage a widespread concern, the restricted time that Home Carers had was considered incompatible with the team approach which, when operating at its best, allows time to get to know and support thoroughly the service user and, in so doing, reduces the need to escalate support and even hospital admissions. The particular irony here is that the Home Carers themselves are reporting feeling more engaged and valued, but are still perceived across the team as being somewhat restricted by time. It would be worth investigating further to see if there is scope to build on the sense of greater empowerment and at the same time increase capacity at the very frontline of the delivery of support.

5 Summary

Structural and organisational change have been required for the successful development of the ICST. One would not have come about without the other, but the cultural changes have been surprisingly hard to achieve and work will be need to be ongoing to achieve full, seamless integration.

Staff acknowledged a fairly high level of entrenchment in their different professional ‘camps’ in the lead up to integration. This has changed to a much reduced level and was mainly attributed to the organised and self-driven efforts to get to know and understand each other’s roles. The surprise for this researcher was that the ‘getting to know you’ aspect of integration was not only between health and social work, but within and across health disciplines as well. It would seem that integration, like charity, begins at home! Improved knowledge of each other has undoubtedly led to swifter more informal communications.

There is now quite a strong sense of identity across the ICST associated with its shared purpose, but not all staff are reporting greater autonomy to work flexibly around patients/services users – with processes and paperwork remaining largely the same as was in use prior to the ICST’s development. This limits the ability to create a ‘whole team approach’ centred on personal outcomes. Such administrative change will of course be difficult and technically challenging, but many staff saw improvements in this area as a desirable change that would lead to better outcomes for the people being supported.

Accompanying this sense of identity, was increased awareness and value being placed on the roles of colleagues in other disciplines. In some cases this had required a lessening of sensibilities – as one person put it, “not to be offended when someone doesn’t understand where you are coming from”.

A key change in attitude has been that towards wider engagement with other support agencies. One team member said that she didn’t used to think this was part of her role, but now she does. This represents a significant and positive culture shift and is one that appears to be supported from the top down.

It would seem then that most of the changes have been around behaviours and attitude, with fundamental practice being constrained to an extent by traditional professional lines. The ICST could, therefore be described as having achieved much through partial integration and could achieve even more by continuing on this path.
6 Acknowledgements

The author wishes to thank the team members who participated in the discussion groups listed below, as well as Team Leaders Morag Dixon, Stuart Philips, and Jenny Butchart for their contributions. Thanks also to the management teams in NHS Lanarkshire and South Lanarkshire Council: Liz Swan, Morag Hearty, Antoni Anderson and Cianna Stewart. Last, but not least, thanks to Barbara McAuley of South Lanarkshire Carers Network for her invaluable perspective.

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<thead>
<tr>
<th>Staff Discussion Groups</th>
<th>Role</th>
<th>Base</th>
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<tbody>
<tr>
<td>Group 1</td>
<td>Jill Mc Gregor</td>
<td>NHS Occupational Therapist</td>
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<td>Gillian Murphy</td>
<td>LA Occupational Therapist</td>
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<td></td>
<td>Julie Anne Muir</td>
<td>Administrator</td>
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<td></td>
<td>Lorna Walker</td>
<td>District Nurse</td>
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<td>Group 2</td>
<td>Anne Cullen</td>
<td>Nurse</td>
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<td></td>
<td>Jillian Gourlay</td>
<td>LA Occupational Therapist</td>
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<td></td>
<td>Veronica Langlands</td>
<td>Nurse</td>
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<td></td>
<td>Elaine Learmonth</td>
<td>Nurse (Overnight Team)</td>
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<td></td>
<td>Tomi Aliu</td>
<td>Physiotherapist</td>
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<td></td>
<td>Jean Cassidy</td>
<td>Social Worker</td>
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<td>Group 3</td>
<td>Linda Barbour</td>
<td>Support Worker</td>
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<td></td>
<td>Fiona Francis</td>
<td>LA Occupational Therapist</td>
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<td></td>
<td>Lynn Little</td>
<td>LA Home Carer Manager</td>
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<td></td>
<td>Ann Docherty</td>
<td>Occupational Therapy Support Worker</td>
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<td></td>
<td>Jacquie Fox</td>
<td>Nurse</td>
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<tr>
<td>Group 4</td>
<td>Margo Pate</td>
<td>Nurse</td>
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<td></td>
<td>Joanne Jenkins</td>
<td>District Nurse</td>
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<td></td>
<td>Julie Livingston</td>
<td>LA Occupational Therapist</td>
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<tr>
<td></td>
<td>Jacqueline Sorbie</td>
<td>LA Community Co-ordinator (Continuing Team)</td>
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<td></td>
<td>Pauline Cush</td>
<td>Support Worker</td>
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</table>

By Employer
- NHS: 13
- Local Authority: 7

By Role
- NHS OT’s: 1
- LA Occupational Therapist: 4
- OT Support Worker: 1
- NHS Support Worker: 2
- Nurses: 5
- District Nurses: 2
- Local Authority Home Carer Manager: 1
- Community Co-ordinator: 1
- Physiotherapist: 1
- Social Worker: 1
- Administrator: 1

By Location
- Greenhills: 4
- Hunter: 4
- Strathaven: 4
- Hairmyres: 1
- South Lanarkshire Council: 7
Prompter questions and suggestion on what might have changed for frontline staff

User and carer interviews follow a personal outcomes based approach. Any training associated with this? Any models followed. How was knowledge transferred into practice? E.g. Taking Points, etc. Are people aware of the personal outcomes toolkit on IRISS website?

Models of professional relationship have changed. What were the adjustments?

‘Everyone’ now involved in identifying goals with the service user. Who is included? What is the wider collaboration? How is this different to what you did before? Why does community team think people in hospital don’t get as individual a response? Are there limitations to the integrated set up, i.e. who is not included in the team or part of the collaborative approach, e.g. voluntary sector organisations, specialists within statutory health and social care?

Service is now more immediately responsive. What if that is not what a person needs? How do you reconcile this with the personal outcomes based approach?

Multi-disciplinary team meetings. What are the changes in terms of leadership? Is there greater scope for leadership at all levels? Have new skills or attributes been needed?

Flexible Care Planning. Were there learning and development requirements associated with this? Are there technical or other challenges integrating systems.

Closer relationships between health and social care staff. What enabling factors create this closer working relationship? What are the cultural differences and challenges? How complete and seamless are these relationships, e.g. with hospital based staff? Are there limitations, e.g. pre discharge? How many cases actually require cross department working? Is dislocation of Social Work Department an issue? If so, what skills/attributes/paperwork or technology are needed to overcome this?

Improved status and recognition for home care workers. How has this been achieved? What has changed for colleagues to give this improved status?

Greater confidence in judgement. Whose confidence is greater? Those making judgements or colleagues within the ‘sphere’ of integration? Co-location. How important is it for confidence in colleague judgement?

Managing family/carer relationships differently. What has changed? Do changes to leadership approach play a part? Are family’s ‘allowed’ to lead?

Better Communications. At all levels? Did staff have to learn to be more empathetic with verbal communications?
Questions for Team Leaders and their answers

1 Leadership generally

Q: What if anything did you change have you had to change in your leadership approach to achieve integrated working? What steps did you or would you consciously take in preparation for integration?

A: It hadn’t occurred that there would such difficulties and challenges in terms of leading the different professions – each with its own professional structure and hierarchy, so a pre-thought out approach had simply not featured.

There were challenges being accepted as the operational lead because some staff reverted to the people responsible for their professional development for management and leadership. This was particularly noticeable around conflict management. Prior recognition of this issue would have helped prepare for integration.

2 Widening the sphere of integration

Q: An observation of ICST, so far, is that it has improved inter-departmental working within the NHS elements of the team. What was preventing this from happening without integration?

A: It was accepted that, in this case, integration has been a process that has radiated out from the NHS and, in theory, there was nothing stopping those better communications from happening prior to integration. However, the ‘formality’ of the structural changes acted as a catalyst for change and without them it is unlikely that the inter-professional relationships and communications would have improved as radically.

Q: There are efforts being made already by some staff to widen the scope of integrated practice to include voluntary and independent (private) sector organisations. How far can the ICST take this practice?

A: The team leaders see it as part of their role to facilitate access to community-based resources. The leaders attributed the improved joint working with carers support to the drive and enthusiasm of the Carers Resources Development Officer.

3 Personal outcomes approaches

Q: Running alongside the national agendas of Integration, Personalisation and Self Directed Support, is a drive towards making working practices more focussed on personal outcomes. So far, not everyone in the team appears to be fully conversant with what this shift means for their practice. Team members have explained that they have always focussed on individual needs and been ‘person centred’, but has there been any learning and development need identified to achieve a shift to an outcomes focussed approach?

A: Some personal outcomes training is now being rolled out in social work and it is believed that this may be extended into the health component of the ICST, but at the moment, in health, the connections are not really being made in staff thinking about what this shift in approach has to do with practice nearer to the ‘discharge end’ of the process.
4 Empowering the frontline

Q: Most, staff welcomed the fact that Home Carers are now more encouraged to make direct contact with other ICST colleagues to raise queries and contribute knowledge. How much emphasis is placed through leadership on a ‘whole team, all levels approach’ to planning support?

A: Supporting Independence training for all Home Carers was seen as a positive way of engaging these staff with the wider team. The Team Leader for Home Care re-enforced the dominant team view that home carers now felt, by and large, more involved and engaged and empowered to in their role, and to connect to ICST colleagues – although, interestingly, wouldn’t necessarily all see themselves as part of the ICST.

5 Using user, carer and community capacity

Q: Has there been a shift in team leaders approach to encourage colleagues to seek greater input from users and carers to their own support plans?

A: Traditionally seen as the role of social work, but there has been encouragement from more senior managers for health ICST staff to seek greater input from carers in particular and engage with Carers Network, etc.

6 Restrictions and Resources

Q: The teams have pointed out a number of barriers to integration, e.g. lack of understanding of ICST role in the hospital; incompatible IT and lack of IT skills; multiple assessments being carried out along separate traditional professional lines; the resource allocation group processes being restrictive. What would you keep and what would you change?

A: The team leaders reinforced the wider staff view that there remains a lack of understanding of the ICST role in the hospital and called for a PR and education programme! The team leader for the SW managed Home Carers felt that they were still very much on a learning curve in terms of joint working when it comes to shared assessment and resource allocation.

Full integration and co-location was something that the team leaders felt would benefit joint working, as would getting Occupational Therapy and Physiotherapy carrying out electronic assessments that could be shared (apparently still pa paper exercise) and harmonising IT systems generally.

A better understanding of the budget might help people who should not be making assumptions about resource allocation from worrying about it. (Commenting on the phenomena that where there is a resource allocation group people at all levels in the team becomes concerned to restrict use of resources, whether that is their role or not.)

Very positive experience of bringing the overnight team (home care) into Strathaven.

7 Practitioner Group Meetings

Q: It seems that where these work, they work well. Are Team Leaders able to influence things so that the learning from the successful approaches in these meetings is being used to improve the less well functioning meetings?
A: There was recognition that there was a need to better structure the leadership of these meetings, align the sub-teams to geographical areas to make these meeting more relevant and move the discussions further towards practice and less around case review. Furthermore, there was a belief that Social Work do not attend fully. However, one of the team leaders commented that she did not feel empowered to influence change in this area.

8 The ‘Getting to Know You’ Sessions

Q: These were run at the beginning of the integration process and were reported as successful at building relationships across the team. How do team leaders’ envisage sustaining this improvement?

A: These sessions were recognised as having worked quite effectively, they were structured and organised. The team leaders felt there was scope to build more structure into joint induction to ensure that an understanding of roles and ethos across the team is maintained going forward.

9 Communication ‘cascading’ at the beginning of the Integration Process

Q: It has been said that there were mixed messages around the integration process following different organisational lines in the early stages of the development of the ICST. What was your experience of this?

A: The most extreme of the views was that this had been a stressful experience and was even described as traumatic. It was felt that there had been “too many fingers in the pie” (reflecting the messaging) and hard to focus on support of patients over the period of change. The perception in social work was that change along these lines was something that they were more used to and re-organisation had not impacted so much on them.
## Record of conversations with staff teams

Comments in italic are interpretive by researcher. Other comments are quotes or paraphrased from conversation. Comments in red simply denote aspects which are negative or counter to promoting Integration. Comments in green were specifically from the Carer Resource Development Officer.

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<thead>
<tr>
<th>Changes and Challenges</th>
<th>Leadership</th>
<th>Learning and Development</th>
<th>Skills</th>
<th>Other Enabling factors and attributes</th>
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<td><strong>Outcomes for:</strong></td>
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<td>Service Users</td>
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<td>Healthier Living</td>
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<td>Positive Experiences and Outcomes</td>
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<td>✓ Greater mobility</td>
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<td>✓ Less or better managed pain</td>
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<td>✓ Improved well-being</td>
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<td>✓ Less stressed</td>
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<td>✓ Convenience</td>
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<td>✓ Early Intervention</td>
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<tr>
<td>• Greater mobility</td>
<td></td>
<td>Personal Outcomes training was made available to home carers, but not universally available.</td>
<td>Have always had a holistic approach/person-centred approach within profession, but since ICST looking at the person in the broader context, i.e. the other supports they receive. This has required staff to be more accepting of others judgement and using the skill of ‘stepping back from asserting judgement’.</td>
<td>The shift to 24-hour care positive for service users with reduced delays.</td>
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<td>• Less or better managed pain</td>
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<td>(This was seen as positive as staff in different tiers had more ‘say’ over care pathway.)</td>
<td>(However, no sense that people have missed something, as each profession still operates very much on their normal ‘track’ of professional development)</td>
<td>Change of approach to ‘less tick box’. Given ‘permission’ to take more time with service users. Less ‘task focussed’</td>
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<td>• Improved well-being</td>
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<td>However, assessments still very separate and follow traditional professional lines.</td>
<td>(No sense that there was widespread ‘messaging’ about what is involved making the shift to integrated working)</td>
<td>Enabled and given time to make the connections with other professionals. One person reported that previously she did not see this as her job.</td>
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<td>• Less stressed</td>
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<td>(So while everyone involved in identifying goals the processes are not truly integrated.)</td>
<td>‘Triage’ skills have had to be further developed to enable prioritisation as people can come to the team with wide spectrum of needs.</td>
<td>(Major shift of attitude here)</td>
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<td>• Convenience</td>
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<td>More information available collectively across the team means that staff feel better able to lead and direct people towards most suitable services.</td>
<td>New roles being developed with ‘multiple skills’</td>
<td>It was felt that restricted shared access to information about service users through the IT system restricted the care planning process from being all encompassing.</td>
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<td>• Early Intervention</td>
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<td>However, system restrictions, i.e. no universal access to notes means that not everyone feels involved in ‘big decisions’.</td>
<td>Role for Home Carers has become more complex and requires a more sophisticated skill set.</td>
<td>Staff reported awareness of third sector and community capacity. This capacity is not formally factored into assessments, but people are signposted to appropriate community resources.</td>
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<td>Differing approaches being taken at multi-disciplinary team meetings. Strathaven seen as particularly successful as it is inclusive. Other meetings ‘never have a social worker there’. ‘Fortnightly joint meetings don’t have full and adequate representation’. Some more ‘health-based’.</td>
<td>Community role generally more complex, especially joint working around complex situations, e.g. palliative care.</td>
<td>Information from Hospital at point of transition was reported as sometimes poor and there was a sense that hospital staff are not engaged in the same support approach passing patients into a ‘black hole’ from the discharge hub.</td>
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<td><strong>Carers</strong></td>
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<td>Carers are supported</td>
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<td>Carer Champions now in GP Practices. These</td>
<td>The shift to 24-hour care positive for carers.</td>
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<td>SL Carers Support Network would like to</td>
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<td>Positive Outcomes and experiences</td>
<td>Trained staff raise and maintain profile of carers issues and can take lead in signposting others to carer’s resources.</td>
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<td>Positive senior level leadership in Health giving ‘top down support’ has ‘opened doors’ for the Carer Support Team and helped raise ‘carer awareness’ and the profile of the carer service.</td>
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<td>Team Leader model in ICST lends itself to positive collaboration, e.g. Team leader attending Carers Conference.</td>
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<td>See shared inter-organisational personal outcomes focused tools and measures of ‘distance travelled’ in use, but feel that this is a long-way off happening, with separate assessment approaches still the norm.</td>
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<td>Almost all referrals to the Carer Support Service are from Health, suggesting that there is further learning and development to be done amongst Social Work colleagues to get the same profile for carer support.</td>
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<td>The family carer still tends only to be included in SW support planning when they are distressed or where there is an issue. With very few requests for carers support plans. Still some way to go to achieve a shift of culture towards carer being seen as ‘an equal partner in care’, suggesting ongoing learning and development needs.</td>
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<td>Wider access to more forms of supports does lead to greater support for carers.</td>
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<td>The move by ICST to create a single hub for referrals has brought the benefit of creating simpler lines of communication with the carer support team.</td>
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<td>Carer Support representation not into the multi-disciplinary Practitioner Groups yet, but would like to be to ensure carer perspective is ‘on hand’.</td>
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<th>The Workforce Engaged Workforce</th>
<th>Strong belief that role and function of the ICST is not properly understood by hospital staff, with myths and false impression of what the team does. Hospital has ‘different’ target and drivers.</th>
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<td>(So, whole workforce not engaged to deliver towards the same set of outcomes)</td>
<td>‘Getting to know you’ (Team Building/Change Management sessions were, to varying degrees helpful in gaining insights to each other’s roles. The first session was ‘not great’ as ‘too complicated’ and ‘too formal’, with ‘lots of yellow Post Its’. The second session was received the most positively.</td>
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<td>‘Connections much improved’.</td>
<td>‘Getting to know you’ (Team Building/Change Management sessions were, to varying degrees helpful in gaining insights to each other’s roles. The first session was ‘not great’ as ‘too complicated’ and ‘too formal’, with ‘lots of yellow Post Its’. The second session was received the most positively.</td>
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<td>Was a need to lower professional boundaries, although people did not find this particularly difficult one person reported that she had to learn to be less ‘offended’ or less ‘precious’ about role.</td>
<td>Team set up enables closer working relationships to be formed with colleagues.</td>
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<td>More contact means that there is more confidence to refer to each other.</td>
<td>Better relationships were credited with resulting in better links between resources.</td>
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<td>Home Carers more involved and given more information. And are more empowered than before.</td>
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Team meeting work well to promote better professional relations. The tight focus on a fairly distinct group of service users at Strathaven cited as good example, as time was not being wasted waiting to discuss patients the ‘were not theirs’.

| Organisational Effective Resource Use | No appreciable changes to leadership approach. Autonomy of decision-making constrained by need to get ‘justification’ through Resource Allocation Group. Daily or fortnightly multidisciplinary meetings in health have improved communications. Social Work ‘tapping into these, but are not ‘integral’. Shift in leadership approach within multidisciplinary meetings, which involves different people flexibly taking the lead according to individual case. , that ‘two heads are better than one’.
(Requires a genuine acceptance of other’s professional validity) | ‘Learning Curve’ had to be gone through to get to know ‘wider resources’. Still variable knowledge, but improving. ‘Early days’ in using wider community resources’ Learning need identified – Understanding each other’s service standards. Because there are differences. IT systems between health and social work are, at best ‘read only’, i.e. you can see the other department’s assessments, but they are not routinely shared, e.g. OT assessments not ‘visible to health’ Main driver, i.e. to take a collaborative approach to reduce hospital admissions was generally well understood. | ‘Learning Curve’ had to be gone through to get to know ‘wider resources’. Still variable knowledge, but improving. ‘Early days’ in using wider community resources’ Learning need identified – Understanding each other’s service standards. Because there are differences. IT systems between health and social work are, at best ‘read only’, i.e. you can see the other department’s assessments, but they are not routinely shared, e.g. OT assessments not ‘visible to health’ Main driver, i.e. to take a collaborative approach to reduce hospital admissions was generally well understood. |
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| Communications quicker. More confidence to set up joint visits because of ‘open communications, i.e. knowing the colleague. No need to always arrange things via GP. Although “more confident to make calls to GP’s and colleagues” Some GP’S ‘getting used to’ ICST and its role, others don’t understand how the team works. Although noticed that there is a lack of input from Community Mental Health Team. NHS OT, in particular has greater appreciation for Home Carer role, but Home Carers have ‘restricted’ role in terms of time available with service users and are generally low paid so not seen as able to engage as fully with team as might have liked/envisaged. No cohesion between health and social work structures and lack of co-location seen as a restricting factor. “Paperwork is ‘heavier’ now” More efficient visits achieved by linking up with Home Carer to co-ordinate visit. Home Carers can communicate directly with health colleagues directly through ICST number. However, all groups reported dire shortage of Home Carers and that they are ‘too rushed’. (This was seen as a limiting factor) Some practitioners reported that they were now more inclined to use befriender and other organisations that they had not previously linked people to. | Communications quicker. More confidence to set up joint visits because of ‘open communications, i.e. knowing the colleague. No need to always arrange things via GP. Although “more confident to make calls to GP’s and colleagues” Some GP’S ‘getting used to’ ICST and its role, others don’t understand how the team works. Although noticed that there is a lack of input from Community Mental Health Team. NHS OT, in particular has greater appreciation for Home Carer role, but Home Carers have ‘restricted’ role in terms of time available with service users and are generally low paid so not seen as able to engage as fully with team as might have liked/envisaged. No cohesion between health and social work structures and lack of co-location seen as a restricting factor. “Paperwork is ‘heavier’ now” More efficient visits achieved by linking up with Home Carer to co-ordinate visit. Home Carers can communicate directly with health colleagues directly through ICST number. However, all groups reported dire shortage of Home Carers and that they are ‘too rushed’. (This was seen as a limiting factor) Some practitioners reported that they were now more inclined to use befriender and other organisations that they had not previously linked people to. |

- Reduced Hospital admissions
- Earlier Discharge
- Improved Co-ordination
- Improved Communication
- Better appointment keeping
About the Author

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