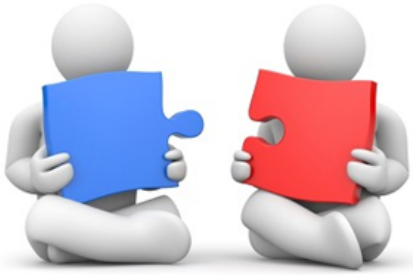
Wokingham's Integration Position Statement



Stakeholder Conversations, June & July 2018 - Feedback

Introduction

The conversations were designed to enable stakeholders to consider 5 key questions about Integration in the context of Wokingham.
Each stakeholder meeting considered the same 5 questions, which were discussed individually or in small groups facilitated by the Better Care Fund Programme Manager. The notes in this paper bring together the suggestions from notes made in each group.

1. What is Integration in adult health and social care?

- People working together across organisational boundaries – working as one for the people.
- Two views of integration – local and BW10. Pathways/Patients/core. Integration of services – locality and or system. Scaling of services, locality flavours
- Taking responsibility
- Pooled budgets (Single funding to break down barriers of different funding streams e.g. CHC or WBC – harder for workers to get approval for more than one funding stream)
- Ability to compromise
- Understanding all organisations priorities etc.
- Single model of service, with health and social care and the voluntary sector being part of that one combined service.
- Integration would mean less battles between organisations, too many barriers and hoops currently
- Lack of drive and clarity from a system level currently. Look at what works in other areas e.g. Manchester – integration of commissioning and provision teams (pooled health and social care budget), driven by Great Manchester health and social care partnership. They have combined working with LA & Health, and promoting that fact – e.g. branded lanyards, TUPE'ing of staff. And Oldham – neighbourhood integrated teams – based in GP surgeries, divided into 6 clusters and teams based around those clusters.
- What do we need for our population? E.g. LD – health and social care.
- For relatively small amounts of money have to do an awful lot.
- Need to be involved strategically
- Who pulls together? Why are you doing it? Clear purpose needed
- Using overview and scrutiny committee to support the strengths based approach – what can you do for yourself?
- Is it integration if it is just health and local authority making decisions? Silos still.
- Cultural change across all organisations e.g. consultant deciding and information re care destination, then has to be unpicked by community H&SC teams. We are here for the people.
- Clear leadership and governance
- Objectives of the service are the same – as opposed to just their organisation
- Alignment to avoid pulling of staff and services by organisations
- Strategic roles to play – objectives for leaders should align – meets all organisations leads
- Partnership working
- Opportunities to share and learn from other professionals/organisations
- Linking up of systems
- Streamlining pathways
- Southampton – DTA model – 3 pathways – simple – rehab/reable, complex – safeguarding, CHC etc.
- Learning organisation e.g. removal of risk averseness
- It would get rid of burn out as staff get so frustrated
- Modifying behaviour – looking at where people feel pressure – how people manage their time? Effectiveness e.g. if managed properly by air traffic control, no air crashes.
- Trusted assessor and single assessment paperwork - users only have 1 plan and organisations have access to the same information about users
- Trust – professional judgement, 2 way conversations, good, supportive relationships and communications
- Shouldn't be – this is my client, not yours. Not what we do and fob off.

- No more silo working or old fashioned-ness e.g. who the key holder is
- Recognising plurality and recognising the benefit for the user
- Understanding and respecting all professional roles and not being precious about roles
- Expansion of roles and increasing staff skills-base. Blurring of roles - fluidity
- There is a 'village' of knowledge and expertise – foot clinic, vascular, endocrine, podiatry, orthotics
- Communicating clear messages to users and professionals to maximise engagement.
- Truly integrated - removal of all boundaries
- Seems like one organisation
- Workforce – generic – HCA acute, comm etc.
- Fit of the acute model – how to take specialist services out into the community
- Single model of service, health and social care part and parcel of one service. More than just health and social care – combination of everyone coming together e.g. voluntary sector partnership
- A broader partnership with voluntary sector
- Voluntary sector – one team – use a simple form
- Smarter working and clarity – a single commissioner of voluntary sector, not health and social care commissioning separately
- Process for engaging voluntary sector isn't right
- Engaging with voluntary sector in the right way – really have a voice
- Seamless user journey – LEAN - navigated easily through the system, no handoffs or duplication, no lengthy referral forms, continuity of care to support better patient outcomes
- Wraparound services for the customer
- Best outcomes for the individual!
- Referrals made to the appropriate professional at the appropriate time, right person does the right part of care
- Customers only tell their story once
- Services designed/aligned to meet user and not organisational needs
- Users receive care in the most effective, holistic and consistent way irrespective of who they are sat in front of (reducing duplication, reducing confusion for users, only sending one person as opposed to many)
- Maximising users own abilities
- Greater focus on prevention and pro-active care. Bracknell have 'Bracknell Help Yourself'
- Sharing of (relevant) user information and access to records, to join up a person's care and safeguard
- The customer doesn't know that there are different people/organisations involved in their care – they shouldn't feel like they are 'handed over'.
- Patients don't really see the separate organisations e.g. ACU
- Person/patient centred e.g. IDT team – doesn't matter who employs them.
- One message – helps manage user expectations.
- 50-60% of patients don't need ongoing care after rehabilitation/reablement
- Building resilient communities – Education in schools? Link in with WBC – project
- People want simplification – things need to make sense
- Person and brand

Stakeholders also described what integrated care wasn't:

- A single health and social care organisation
- Suspicion – needs to be trust
- Blame
- Doesn't feel like a reality - more aspirational
- Challenges around cascading/sharing information
- Patients don't really see the separate organisations e.g. ACU

Barriers/ways to improve:

- Use the Integrated Hub
- Band 2/3 staff working as administrator

- Don't have the tools to guide or navigate through patients on the system
- Every patient is primary care's problem
- Other services have a more defined caseload of patients/users
- Need to stop batting off patients between services e.g. "not my remit", "not my problem", "doesn't meet our criteria"
- GP/District Nurse interface would be key for primary care and would improve care and organisational relationships e.g. core/non-core DN contract is stiffening the boundaries and not adding flexibility – risk to integration. For the patient – just help them.

2. Why should Integration be a focus for all?

- Thinking about collaborative working e.g. speciality services will often go for discharge.
- To avoid repetition and time wasting
- To give a wraparound service for the user and improve outcomes
- Single assessments would benefit the user – telling their story only once, trusting the assessment is to the same level across boundaries
- Safeguarding – integration would keep people safer e.g. knowing which other services were involved in the person's case.
- One communication channel works; open dialogue is the only way at the moment – key enablers – people involved, nature of the care and one person driving it.
- To better manage spend and have a more streamlined, efficient and able workforce & to meet demand
- To reduce repeated non-elective attendances – encouraging and empowering people to self-manage their care
- Moving away from the demand-led provision of service will future proof services and enable better planning of resources and give opportunities to improve services to the user. Proactive rather than reactive.
- To reduce complaints
- To reduce waiting times – look at what services can be provided in the community instead of acute.
- Facilitating a more timely and seamless service to the user, reduce their frustration and prevent re-referrals
- To reduce unnecessary paperwork
- To break down barriers
- To promote strategic partnerships across the system & all partners to take ownership
- Why wouldn't you integrate?
- Seen that it is best practice across the country; finances – how best to spend the money to deliver the right service.
- Remember the patient is at the heart – all about the people that we serve and look after and care should be the same for everyone.
- Relinquishing control and stop playing one organisation off against another
- Protectionism – stopping it
- Working together to one common aim of delivery of best service.
- Put the user first
- Maximise outcomes
- Personally/professionally richer
- Economy of scale
- Employee perspective – benefits to working collaboratively
- Dysfunctional system and ways of working – opportunities needed for efficiencies and better patient care; if issues were sorted, e.g. Hub & DNs = faster integration as GPs values workload, system savings, turnaround thinking
- Need to stop silo working
- Avoid the crisis for the person
- Behave differently, fix things, the ripple effect
- Working together, creatively, holistically, efficiently
- More time for those that need it most.

- Best outcomes- communities, societies etc.
- Improve patient care
- Enjoyable for workforce – recruit and retain, 'together we achieve more'
- Modern healthcare is MDT – team based approach

Barriers/challenges –

- Historically, services have been insular and done their own thing for a long time.
- IT systems don't speak to each other, resorting to using printed information
- Different people have different levels of access to user information, which could impact on the person's care/safety.
- Private funders add complications as more limited to make changes or increases or don't want to pay for care at all
- Knowing who to go to, understanding different roles and responsibilities.
- No evidence that it saves money, so difficult to do – underestimate the difference, legislative frameworks are different
- Variations between other local authorities. LAs share political leadership, who decides how money is spent and collected
- No combined authority at a Berkshire West level – what is their commitment?
- Conflicting organisational priorities – what are they?
- Stop-start services being seen as the solution – old culture to new culture – created nanny state
- Will it understand, hear, listen, what the person needs? Will it have an outcome? Will we be able to travel the journey to the end?

3. Where have we got to with Integration?

- MDTs have made a real positive change to partner working and improving outcomes for the person and relationship development with practices and wider system; people are trying to help with problems that primary care have.
- Improved cross-organisational relationships
- Approximately 50% staff have access to Connected Care
- Recognition that integration is needed and the path we will be following; still a long way to go and scale and pace needs to be considered carefully.
- Opportunity to be involved and embrace some of the vanguards and new models
- Our key enablers are: IT systems, facilities and the infrastructure behind that, joint workforce plan, joint training
- Co-located teams, empowering staff to look towards change and engagement. Works well with the teams based at The Old Forge for example – easier to communicate with colleagues. Multi-disciplinary triage at 'front door'.
- The CCG are considered good at dealing with projects, changes etc. How does the NHS bring the Local Authorities along with it?
- Health and wellbeing board are multi-organisational, although few constants (CCG & Healthwatch)
- Starting to share good news
- SPA located
- HWB facilitated workshop – how the board drives improvement of health in the borough.
- More aware of CHASC than WISH
- The Hub ability has been good
- Got a model but it needs work, to be more integrated
- GP Alliance involvement and not just from commissioning
- Conversations with BHFT around shared services
- CNS – feelings are positive and helpful but some Practice Managers moan about them as it creates more work for them.
- Health and social care pockets of excellence (though some areas are still battling)

- Care Homes, Getting Home, IDT
- Learnt from experience – ICS – tried things and stopped if not working
- Functional integration of WISH joint (senior) leadership – there was a united management front, which was a driving force
- Limited with the acute sector
- Single CCG across Berkshire West
- Clearly steps have been made through BCF, HWB, and Wokingham Integrated Partnership
- Integration through CHASC and WISH
- Some people are not sure really how far we have gone/got
- Locality and system flavour
- Some new and different steps, some are more of the same.
- Critical partners – voluntary sector
- Building relationships
- Integration means different things to different people, therefore we are in different places
- GPs think we are somewhere that we aren't
- We have a vehicle in place to start to deliver and at scale we can do
- By-products of MDTs – informal integration and relationship development

Barriers/Improvements needed:

- No resolution with record sharing; Connected Care is 'patchy', dependent on user level access, can't copy/print. Restriction on records of people/residents who have refused to be involved.
- IT systems don't talk to one another
- Still hard to find out who is involved in a person's care.
- Communication re services e.g. changes to hospital or other services, between acute and community hospitals, pathways
- Communications to staff – multiple methods would help spread of information e.g. newsletters, intranet, emails, team meetings
- Inappropriate use of services e.g. GPs misusing RRAT service
- A number of 'false starts' – wasting money, ROI, benefits etc.
- Better transparency for information sharing – keep it clear and simple; everyone's responsibility.
- Cultural change can take a number of years to embed – there will be a time of testing and adjusting and it is imperative to get buy in from everyone – workforce, strategic management, Members and the public.
- Still see a big divide with Local Authorities and NHS
- Turnaround of staff in the Local Authority is a key issue – lots of interim staff (all levels)
- Different statutory duties between organisations.
- Different organisations have different priorities.
- Competitive market for providers
- Differences between NHS free at point of access & then means tested with social care – work and time taken to determine what is paid for and by whom.
- Pathway processes need improvement.
- Can be difficult to co-locate teams
- Shouldn't be a divide between CHASC and WISH
- How to integrate with long-term service? Hand offs
- Barrier with acute – not really included
- Co-location of WISH team at the Old Forge has created a divide elsewhere
- Two different team names has created a divide (social care)
- Is WISH really integrated or just co-located with other services?
- From a primary care point of view – the negative view of the WISH team is purely because of calling capacity
- New members of staff may struggle – with other social care staff/teams.
- Need to plan ahead. Divide between strategic and operational
- Values – need to collaborate, not compete
- Primary care on the ground have not really bought into it yet – been pulled along a little but not all the way
- Funding is an issue for GPs – they don't get the numbers

- Section 117 & CHC – what is the criteria? Joined up conversations needed
- Political issues – blame culture from politicians
- Pressure points and flexing across the system
- Empire building
- Look at culture change
- Not hearing about major changes that have worked (or not)
- Still have many of the same issues – people falling through gaps. GPs feeling the pressure, people still going to A&E
- Voluntary sector still feel overwhelmed.
- Voluntary sector – single services across the borough
- How do we get the voluntary sector to work together?
- Transition – Children's
- Single door that everyone comes through
- Still multiple departments
- Still examples of lack of team work – e.g. receiving a call this isn't for you, telling the caller to call someone else who may be sat next to them!
- One way referral e.g. A&E – specialty; specialty says no and refers back to A&E

4. Where are we heading?

- More discussion around seamless provision of care.
- More facilities in the community for sub-acute care for patients to prevent hospital admission
- Organisation barriers are beginning to break down, we need to continue with this way of thinking to fully integrate
- All the services have the same understanding – clear purpose and proposal
- Integration has begun but will take an immeasurable amount of time to embed
- Encouraging early intervention - increasing support needed from the voluntary sector and to educate / encourage service users to self-help and take responsibility.
- Look at the wider picture, not just focussing on health and social care – extend to housing, education, fire, police etc.
- Scope for prevention with LTCs in CHASC – targeted approach e.g. COPD prevention and stop smoking support.
- Referral processes – 1 single referral for all, 1 single assessment
- Need to progress with minimising bureaucracy, form filling, methods of referral to make it easier for staff on the front line and for users to access appropriate services quicker.
- Think about targets for all parts of the system e.g. reduction in primary care activity.
- Positive outcomes have been seen [for the patient]
- Locality team joint working is positive
- See localities functioning as localities – need to include the admin side of things.
- Partnership working – locality, system-wide, thinking strategically.
- Be more proactive than reactive
- Always looking at ways to improve, although it doesn't feel like it's embedded across all as yet.
- Planning 80% plans & comms (continual cycle of comms and sharing) 20% in delivery
- We should be heading towards absolute integration, in theory the best place
- Local need says we need to do something
- Heading to a happy medium – influences
- Collaborative approach to delivering integrated care – is that what we are talking about?
- What is the remit? Use SCIE model
- Commissioning – who/which services need to come together
- Currently shaping commissioning for WBC – move from reactive to strategic between CCGs and Local Authorities.

Barriers/ways to improve:

- Keep heading in the same direction as in the last 10 years – where/when/how to successfully implement change
- Main barrier – IT systems not talking to one another, lack of information in Connected Care, Framework I etc. Single IT solution would help.
- New workforce members need to understand roles and responsibilities of their own and other services, how we are all dependent on each other – as part of inductions perhaps?
- Staff can be 'protected' by managers due to workload pressures – doesn't tie in with open/honest communications.
- Make time for face to face interaction
- Incentives have to be right to get to where we want e.g. GP funding
- Organisations need to buy in to integration
- With ICS taking over and the focus on the ICS and the difficulties linked with that – based on goodwill of the partners
- Direction of travel could change with the government changing
- How do we incorporate Children's Services into the mix, who takes responsibility for that? If we don't get in early to educate young people it would be a waste – how do we get the message across?
- Funding will always be an issue – there isn't an infinite amount of monies to fund progress e.g. financial support to voluntary sector which could affect response times.
- Support and development of community enablers, to avoid the voluntary sector being left behind.
- No reward/incentives for volunteers.
- Use assets better e.g. community transport
- Ability to network and develop relationships – need the time to do this
- Paperwork/Pathways/Systems all need to be aligned to improve relationships
- Champions – organisations – roles and responsibilities
- 'Singing off the same hymn sheet'
- Tension between locality and system working, how do you resolve e.g. Berks-wide Hub, Community Nursing?
- Have all partners really bought into the model?
- Bureaucracy with larger organisations; different size organisations have different levels of flexibility – need to reduce the bureaucracy.
- Reduce workload with referrals and management
- Need to build on trust across all organisations – GPs feel that they aren't trusted which creates angst.
- Risks – insular organisations due to finance pressures
- Pilot schemes should be pilots – people are afraid to try things out.
- Should know better after the 8HICM this is really valuable and realistic
- Acute bought into the process
- Is it clear at the moment as to where we are heading?
- How do messages get to the relevant areas and filter down?
- Still large hurdles to overcome – articulation/comms (linking ambitions), on-boarding, one team – one message
- Consider the political agenda
- Not articulated well where we are heading e.g. services wrapping around the individual
- What is in the Wokingham gift?
- What is in the BW10 gift?
- What is in the ICS gift?
- Mindful of tricky things – what do we really need to do/quick wins/what is difficult to do
- ICS approach - alignment
- System – topped out
- Unified Execs
- Pull model – pilot/roll out – proper Discharge to Assess – Trusted Assessor model
- Ask the right questions of the client e.g. what is the reason you need support overnight?
- Understand funding dependencies

5. How are we going to get there?

- At meetings – networking
- Informal and formal meetings and team briefings to support joined up thinking - People need the motivation and will power to push forward.
- Imperative that system leadership sets the tone and supports the direction of travel. There must be buy in! Not just from Wokingham leaders, but there needs to be national consideration to change how organisations can integrate and work together better (including shared records and paperwork).
- Lead by example – have a clear vision, clear road map to where you want to go, align elements as you go. (sustainability/ownership/drive/time)
- Build on the philosophy
- Independent review of services/systems to identify inefficiencies
- SMART planning – 2/5/10 year vision/plan/strategy
- Turn multiple initiatives into a single initiative e.g. Dementia Town, Healthy Towns etc. – would need to look at how to pull it all together.
- Consider the utopian view and how could we achieve that. Need a clear direction and share that with workforce/public. Public aren't really interested in 'how' we get there, but 'when' and how it will impact on them.
- Information sharing needs to be understandable and comprehensible – 'plain English'. Use various methods of communication, timely and clear for both the public and staff. Don't forget about Sam's Story – move him forward (our original IPS for Wokingham).
- There needs to be mutual trust between organisations and colleagues.
- Implement the social care pathway
- Look at the practicalities of how to move forward – need the time for prep and planning the steps on how to progress, including the detail and support for staff with the change in directional shift
- Clarity of direction of travel between Berkshire West and local levels
- Closer working with Public Health
- Clarity of purpose – be clear about what we can do, but also what we can't
- Strengthening the MDT teams in clusters around GP localities, GPs managing demand
- Virtual or co-located teams – good communication between services is key to success
- Economy of scale – big issue – no resilience. Things have to be at a certain scale for efficiency and things working – single pathway.
- Greater engagement of GPs, to better support the acute service.
- Be able to hold ourselves to account in terms of delivery.
- Creating a common shared vision – who does it mean?
- Clear scope for integration – set basic parameters to move onto how we can work better at an operational level.
- Aim for best delivery – e.g. ways practices are developed and employed e.g. for mental health it would be service or specific interventions.
- Access to IT systems wherever practical – log in for others systems? Giving people permission to do what they need to.
- Investing up front
- Needs to be really well thought out and really clear, good direction
- Think about how to remove barriers for:
    1. IT
    2. Funding
    3. Comms
    4. Pathways
    5. Make sure you are sorted in house
- Fundamental changes to processes e.g. Hub
- Let localities function as localities

- Commissioning of services – what works at system level, what works at locality level
- Organisational politics – need to be aware of sustainability of organisations but don't let them hold it over to not deliver the most ideal model
- Contracting for outcomes – less prescriptive? E.g. core/non-core
- Think about branding e.g. when you buy ketchup from Heinz, it is the same end product everywhere. That builds customer confidence and brings things together. Leadership to give this type of message.
- Things have to make sense to the people e.g. Bracknell Health Space has 1 reception but 2 staff, 1 for FPH and 1 for RBFT – why?
- Think of the simple things – shared training and staff recruitment, still sharing seconding etc.
- Inclusive to the voluntary sector, care sector
- Bold and radical – starting again. The world has changed so much, why are we adapting and tweaking.
- How much money do we have in the Wokingham system? For health and social care
- Look at the borough – what does it need/want?
- What is within local control to deliver, what is in the system control to deliver?
- Consistent commissioning – SMART
- What are we really doing about early intervention and prevention? Catch early on - from birth with families
- Smarter thinking, smarter one off things
- Who are the right partners?
- Buy-in from all stakeholders for consistency; don't keep adding/bolting on.
- Learning – how we get there, don't disregard anything, don't be afraid to test, be pragmatic.
- What do we want to achieve? Strengthening resistance e.g. public health
- Single set of objectives
- Removing variance
- Ethos, Core Values, Culture Change, Communications - articulated cascade of info
- Workforce – gain a collective view about how we plan for the future – creative view
- Not asking people to work outside professional boundaries – just to work holistically.
- SDs – signposting, holistically treat/manage patients
- What it should mean for each area e.g. brokerage, community nurses, RRAT etc.
- All staff introduce themselves as working for Wokingham Integrated Care – not their own organisation
- Building relationships and trust are essential
- Permission for those at the bottom to take risks
- Leadership – topped out
- Working as a whole system – why should Local Authorities do DTA? It's all about reablement – supporting Local Authorities to deliver 'Home First'
- People shouldn't come into hospital and never go back home
- Breaking down barriers – rotating staff – transition of users
- Joint commissioning – links between BCF and Commissioning. Who is leading on joint commissioning now? What to joint commission?
- How do we engage members in decision making early on? How to 'warm them up'

Barriers/ways to improve:

- WISH team not bought in and not communicated to about CHASC
- RR, ICT, Criteria – more info needed
- Referrals – making processes quicker and easier; a single, simple form
- Quid pro quo too – what deals are there to be had? E.g. primary care and BHFT
- Ideological – when not involved in it, it can be very different when looking from the outside.
- Politics from joint commissioning e.g. Local Authorities that won't agree – which pair up People need warming up, politically
- Needs to be strategic
- Transition – how do we do it, don't destabilise or overlook unintended consequences