IJB Quality and Performance Sub Group

Meeting 1 – 21 April 2016

Session Aims

- Story so far
- Case study and reflections (video and activity)
- Performance and the Strategic Plan – Exploring Rubrics (group activity)
- Agree approach and next steps

Jenny's story – Reflection Activity

1. What can we learn from this that will make Integration really work?

- Communication: How to refer to Social Care Direct etc.
- What would have happened if she'd been alone
- Why so the package was so inflexible
- Fragmented
- Did she have a ward assessment?
- Too many people – no one taking charge / co-ordination
- It's about bringing people together
- We react to failure just now (package ended)
- Simplify communication routes / access routes (and don't keep changing)
- Ownership and responsibility
- A co-ordinator
- People too passive
- Awareness of everyone of everyone else's side
- 5 out of 6 of cases encounter issues like this
- Some individuals don't fit into existing neat "boxes"
- In this case, a greater exploration at the start would have helped avoid admission
- Clunky process to access care
- Jenny ended up as default care manager
- Clearly allocate responsibility and authority to manage care
- Co-ordination; what happens when there are no family to support / co-ordinate
- Communication between professionals
- 'Systems' and 'processes' are still separate
- Responsiveness – procedures where possible at home
- Are we meeting personal outcomes – POCS to be agreed / planned
- Don't make 'assumption of dependence'
- What can families provide – they can be assets

2. Write a group pledge to Jenny and explain how her contribution will help us to learn and improve

- Jenny's contribution will help us learn and improve by listening more, understand what matters to you, and ensure that you are not expected to be the person connecting the "bubble" of care.
- Listen and take wishes into account
- Recognise that systems can be barriers to flexible and response service delivery and support
- Strategic plan – joined up between hospital and communication settings
- ID a care co-coordinator (someone in the hub)
- A proper role with sufficient time to do it (not an add on)
- Remember her and her story when we plan
- Continue good care and smooth the journey
- Sort the transition – the processes
- ARU

3. What ideas do you have on how we could gather other examples / case studies / people experiences (positive and negative) and share them at future meetings

- EVOC – Adocard
- Complaints
- Good prompt for discussion
- Actual experience
- Look for examples of cases/ issues
- Selection from scenarios from:
  - *Delayed discharge*
  - *Care home services, hospital to home*
  - *Care home admission to hospital*
  - *Hospital to home*
  - *Positive and negative*
  - *Develop "perfect journey outcome"*
  - *Develop "worst outcomes"*
  - *Associate to board*
  - *IJB*
  - *KPIS*
  - *National measure chart*
- Pathway studies
- Looking at a sample of service users pathways in the system / databases. Then taking a smaller sample from this to get more qualitative personalised feedback directly from the users
- E.g. waiting times, number of times passed through teams etc

Strategic Plan Action 1: Establish local collaborative working arrangements across partners

From April 2016 the four Health and Social Care Locality Managers will ensure that local health, social care, third, independent and housing sector providers, along with unpaid carer and service user representatives and other local organisations, are able to work effectively together by establishing collaborative working arrangements in each locality.

What does excellent look like?

- Communication and data sharing across all parties
- More emphasis on clusters
- All parties have equal opportunity to influence and recognise each other's right profile
- Honest conversations – beyond tokenism in relationships (meaningful engagement)
- Acting on conversations / tests of change
- Making sure performance monitoring is as broad as possible
- Much more emphasis on prevention
- Partner organisations know their place in the spectrum of services. No gaps or game-playing
- Great literature
- Wide range of community groups involved
- Assumption that everyone is working to support the service user
- "pull" model from community
- Confidence in the system among service users and families
- A common language
- Services are shaped by fabulous locality planning group
- Activity tackling priorities. Redesign never stops – a learning partnership

What does acceptable look like?

- Do no harm
- Increasingly able to identify the 'goal' and able to measure progress
- We know whose goal it is and have some ownership of this
- More understanding of prevention and directing resources towards this. We have convinced people and won argument
- Active engagement to seek participation in partnership
- Community group engagement valued
- Don't want to settle for acceptable – need to ensure services don't stop here.
- Productive, vibrant, representative locality planning group with everyone's roles heard
- Can see that feedback is improving from staff to service users
- Ready to tackle priorities – we know what they are
- Shorter, more efficient pathways
- Live within financial means

What does poor look like?

- Misalignment of services – gaps
- Many complaints and poor feedback
- Health, SW Working together but with nobody else
- Wasteful
- Lots of phone calls to different services by Jenny
- Costs of replication, waste of time
- Poor communication
- Measurable things will be poor
- Inappropriate info sharing
- Poor outcomes, more harm, more delays
- Resignation and acceptance – low expectations
- Measurement of wrong things – imbalances in provision
- "push" model from acute care
- Blame culture
- Constant "no money" response. No point in developing anything
- Unwillingness to look at things that are not working - keeping doing these things!
- Those who shout the loudest get the most
- We have the WRONG priorities

Strategic Plan Action 3: Establishment of locality hubs

A priority action for the Partnership is to develop hubs within each locality coordinating community resources more effectively in order to:

- maximise support for independent living
- provide a community response to urgent need and care crises

reduce the need for admission to hospital

What does excellent look like?	What does acceptable look like?	What does poor look like?
•Hospital for treatment: Home for recovery – why not home for treatment? •Right people, right time, right place = better decision (across hospitals and communities) •Everybody knows what the 'hub' does referrers (providers) users and carers •Improved outcomes: - individual, service, organisational •Able to predict and prevent and where something does go wrong we learn, absorb and grow •Effective horizon scanning •Knowing what the symptoms are that promote preventative and early into measures by measures – less days in hospital bed, less demands on point of discharge •A lead named person for each locality (girfe), coordinates, 'holds'. •Shifting resources to meet balance of care / prevent, prevent, prevent •Not being held hostage by process / procedure/ protocol •Not just referring to hub just because that's what we do •Integration with community sector	•General happiness / satisfaction of service delivery and outcomes "we're not a million miles away" •Safe Care	•Not meeting national targets – knowing why and not acting •Long delays, decisions 'bouncing around' •Lack of ownership of care management •Failure, bad press, reputational damage •Lack of understanding of hubs and huddles •Risk: professionals don't agree or can't move forward / compromise •People still operating in Silos •An over focus on 1 issue (DD) But not having a clear and sustainable impact (long term) •Repeating bad decisions / Not learning •Sending everything to the hubs

Strategic Plan Action 17: Building the wider primary care capacity

We will do this by:

a. identifying ways to maximise the contribution of community nurses who support those with healthcare needs, including frail older people living at home and in care homes, as part of developing a sustainable model of care for this group of people
b. continuing and extending medicines reviews for people taking a large number of medicines (polypharmacy) in care homes and in the community, focused on the high risk groups, linked to "*Prescription for Excellence*" funding
c. expanding the primary care pharmacy workforce, salaried and sessional, to work alongside and support GP practices
d. testing and rolling out models of "teach and treat" polypharmacy clinics to assist patients to better manage their own medicines
e. increasing opportunities for social prescribing for anxiety and depression, for example, as an alternative to prescription medication
f. considering better ways to inform the public of how to access directly health services which do not require a GP referral

What does excellent look like?	What does acceptable look like?	What does poor look like?
•Seeing the right person at the right time (continuity) •Staff having appropriate skill set being used (effective triage) •Single record shared by all •Staff are happy, content and interested in the work they do •People taking responsibilities for themselves •Staff have a clear understanding for all supports available in community and how to access them •Well informed public •Satisfied public (empowered) •Trusted brand •Community based hubs where access to all professionals and wider community assets •Better co-ordination between hospital prescribing and community prescribing •More social prescribing rather than drugs •Healthy population •Range of social prescribing/ therapies available – and people can access it with support if none •Positive impact on persons outcomes •Public are happy to see the right professional •Culture shift in expectations in public, professionals and the government	•Being within drugs budget •Right info to people and professionals about options for where to get support.	•A long wait to see the wrong person or too many people •No continuity of person GP/Nurse •Patient having to chase up •Several records / systems •Lack of GPs, pharmacists, nurses – lack of redesign to do things differently •High sickness absence •High turnover •People go to their hp as the first point of contact (rather than via GP) •Public/patients not happy / impressed /empowered / involved •Hospital admission related to drug interaction (polypharmacy) •Overspend on prescription •More of the same – inappropriate referrals to all community team •No links with wider community assets •GPs / doing tasks that don't need a gp •Professional working to bottom of skill set