KEY TO SITE

D1: purple

D2: orange

D3: green

I1: black

12: blue

I3: red

A. STRATEGY

LONG TERM

48. Create the vision and agree strategy across the health and social care community/ Define a specific strategy for the care of patients aged 85 and over.

49. Aim for integration between care providers, especially community and acute care Trusts and health and social care/ Better integration of acute, community and primary care

50. Involve social services in strategic development , including the need for urgent response
51. Work hard to keep the vision alive over time, through reorganisations and changes in key decision makers
52. Be aware that "big ideas" and "national must dos" come and go; accommodate new initiatives but maintain strategic vision

53. Allow time for relationships to develop between the local partners, involving the emergence of common goals/ Allow time for relationships to develop so that it is possible for this vision to succeed and survive
54. Be bold and acknowledge that some services will be decommissioned in the process of service redesign

55. Avoid tension between localism versus regionalism

MEDIUM TERM

15. Reorganisations affecting commissioners and community providers inevitably cause disruption and need to be risk managed (at system level?). Minimise disruptions due to re-organisations and staff changes Minimise disruptions due to re-organisations and staff changes. Minimise disruption due to re-organisations

56. Admission reduction strategy needs to include investment in primary care
57. When focusing on reconfiguring (hospital) urgent and acute care, consider primary care and urgent care in the community
58. National pressures and targets need to take into account the impact they have on older people
59. Integration of funding and plans is helpful (?)

60. Be aware of the impact immediate pressures can have on the delivery of medium term goals

SHORT TERM

61. Avoid transient pilots with no follow through/ learn more from pilots and implement good practice.

62. Avoid multiple initiatives which are inadequately marketed
63. Colocation, when practical, helps improve interactions between services.

64. Assess measures directed towards productivity and savings carefully and so avoid downside impact on quality and/or capacity

65. Acknowledge the perverse incentives in the system that can influence the behaviour of acute trusts

66. CCG should challenge trusts through active performance management especially on admissions and LOS

67. Consider direct to public marketing to influence health utilisation behaviours

SPARE

68. (Be aware that commissioning services for older people can be compromised by CCG divisions that are not geographically based)

69. (Due to the high levels of HIV & TB within this area, can there be an alternative way in dealing with these specific types of issue (in parallel with conventional admissions)?)
70. (The senior management teams should be encouraged to discuss Strategy with the Trust)
71. (Commissioners should focus on admissions as well as facilitating discharge)
72. Acknowledge that community "beds" is an old and discredited model for care in the community (moved to structures)

B. STRUCTURES AND SYSTEMS

INTEGRATION

1. Vehicles such as system wide Urgent Care Boards can play a key role in overseeing service change and service integration
2. Senior management teams should be encouraged to discuss strategy with partner organisations
3. Integration can be facilitated by leaders in each service stream (primary care, community care, social care) being matched to partner leads in the other services.
4. Clustering services under the same provider can be a constructive strategy through which to foster integration
5. Commissioners may still need to be the medium through which integration is advanced across services and across organisations; this can be specified in contracts but may need support in implementation
6. Integrate social work and nursing teams that cross the boundary between community and hospital.
7. Effort is needed to integrated mental health trusts in system change especially when community staff sits in other organisations
8. Consider how palliative care teams are integrated as part of the overall system of care
9. Address the challenge of creating integrated primary care teams inclusive of general practice. District nursing teams no longer based at GPs – relationships should be re-strengthened with more formal linkages Develop closer operational between Community and Primary Care Services Develop clearer pathways across the region

- Integrate information systems for primary care, WIC , UCC, ACS and social care. Maximise opportunities for co-location of services/ Develop IT systems that are integrated across acute, community and primary care

INTERMEDIATE CARE

10. Intermediate care provision should be integrated with 24/7 availability and a single point of access. Develop SPA for community and IC services. Look to transition from traditional community services to a suite of complementary admission avoidance/early discharge/intermediate care teams. Address complexity by combining and coalescing teams and functions. A single point of contact for GP admissions works well and can signpost GPs to alternatives to admission

11. Acknowledge that community "beds" is an old and discredited model for care in the community. Progress decommissioning of intermediate care beds with shift towards ambulatory and home based care. Intermediate care should provide home based provision to reduce risk of institutionalisation

12. Consider implementing hospital at home teams for early discharge of patients starting usually with orthopaedic patients

13. CCGs could consider using social fund to purchase admission avoidance/supported discharge schemes

14. Assess need for geriatrician input to IC

15. Include palliative care teams in the community care strategy as effective services enable patients to die in their own homes. Develop systems to enable people to die at home

16. Consider telehealth as an addition to community matron provision for COPD and HF.

17. Commission 24/7 response service for people with urgent mental health needs

EMERGENCY CARE

18. Commissioners and providers should support the concept of A&E "front end" and "acute care units" to reduce A&E activity and conversion to hospital admission. (move to systems?) Consider Ambulatory Care Centre to take referrals from GP and divert from ED

19. Consider GP input to MAU (or integrate with PC Assessment unit)

20. GPs can be useful in A&E in signposting patients to more appropriate sources of care

21. Ensure ED provides specialist geriatric cover, preferably 24/7

22. OTs and social workers can play a part in assessing and redirecting patients assessed in A&E and judged vulnerable on account of social needs

23. Implement a system for assessment and management of fallers with ambulance trusts and use this as a platform for exploring the potential to reduce the conveyance of patients with other conditions. Further work is needed to enable ambulance trusts to reduce 999 conveyances and in particular to extend the remit from falls to other conditions More engagement between Acute and Ambulance Trusts

GERIATRIC SERVICES

24. Provide GPs with access to urgent geriatric advice (telephone) and urgent clinic appointments

INPATIENT SERVICES

25. Discharge processes work best when there is a proactive discharge process with acute and community trust working together on transfers of care out of the acute; involves a team of discharge co-ordinators and a regular meeting

GP AND EXTENDED GP SERVICES

26. Means of engaging GPs on urgent care issues needed to be identified and exploited and the performance of the worst in respect of unnecessary admissions needs to be brought up to the performance of the best Tackle variations in GP provision and coverage

27. A roving GP supported by a consultant geriatrician may oversee use of a limited number of “step up” and “step down” beds. “Roving” GPs can play a part in triaging patients who can benefit from inputs from intermediate care teams and so supporting care in the community. Early assessment by a geriatrician may be an appropriate step for some (but not all) of these patients

CARE HOMES

28. Work closely with nursing homes hosting beds to assure that the quality of care in this setting is satisfactory

29. Think carefully about how to support care homes in the management of vulnerable patients with long term conditions

30. Be flexible about community nurses supporting residents of nursing homes

COMMISSIONING

31. Commissioners need to tackle perverse incentives (e.g. MAU classed as admission, PBR versus block contract)

32. Commissioners are purchasing services for their own patients while providers serve more than one commissioner ; mechanisms need to be in place to enable tailoring of services to populations served

33. Commissioners might need to take risks by investing in new models of care that as yet have a poor evidence base

34. Providers prefer broad specifications for service change that are outcomes focused as this enables them to make best use of their resources

35. Invest in the full range of evidence based intermediate care services

C. SHARED VALUES AND STYLE (and skills/staff)

VISION

1. Develop and communicate a shared vision on quality care for older people accommodating medical, functional and managerial perspectives.
2. Share this across the leadership of all involved organisations
3. Work towards seeing people as situated in community and help them continue in that guise:
4. Be proactive in creating the kind of future that is needed; don't wait to be pushed
5. Hospitals see sick people as patients first, community services see them as people first; aim to address this disparity
6. Preserve shared values and mitigate the effects of perverse incentives (e.g. PBR versus block contract)
7. Adopt a clear view of what hospitals do well and what they do not do well. If you are older, hospitals can make you ill/dependent.

CULTURE AND CHANGE

8. Accept and accommodate role changes, including the cultural shift needed for hospital trained staff to work in the community
9. Be innovative and aim to stay ahead of the curve
10. Accept that a key role for NHS managers is to manage uncertainty
11. Acknowledge that new organisations (CCGs) need to find their feet, build relationships

12. Make use of people who have been around a while notwithstanding they might have changes roles
13. Remember social care work at a different pace to the NHS

SKILL MIX AND SKILLS

14. Integrate LTC nurses into IPCTs blending specialist knowledge and generic skills
15. Assure all relevant disciplines are given the opportunity to contribute to MDTs
16. Always look to role extension as an alternative to increasing complexity of MDTs
17. Assure that there is sufficient staff capacity (e.g. Nurses and therapists) to meet demand in new services and that there are geographic disparities in resources (e.g. IPCT resource is patchy)
18. Make use of PAMS; OTs have a particular contribution to make
19. Assess need for geriatrician input to IC
20. Assess need to improve IT systems training
21. Invest effort in developing skills of key groups e.g. staff in care homes

RELATIONSHIPS

22. Consider trust building initiatives to improve relationships between commissioners and providers
23. Community nurses and GPs need to better understand each other's worlds, priorities and ways of working
24. Avoid blaming other organisations or groups for things that aren't going well; collaborative solutions are more likely to work
25. There is no room for ego; focus on the needs of the patient
26. Focus on building relationships and supporting staff through redesign
27. Break down role boundaries wherever they get in the way of effective care

STAFF WELLBEING

28. Manage pressures at work; stretched or stressed staff resort to silo mentality which will ultimately with work counter to integration
29. Protect NHS managers form themselves; some get ill

LEADERSHIP

30. Leadership by key individuals make a difference especially when working across organisations; take advantage of these people
31. Recognise the importance of clinical leadership: clinician managers can offer particular perspectives
32. Remember managers, but not clinicians, have to think about budgets
33. Recognise leadership styles are appropriate to different problems and situations. Aggressive/tenacious leaders can get things done; liberal, inclusive, charismatic leaders-all can be relevant.

SPARE

34. Clinicians- don't complain about problems, engage and help address them
35. Focus on training and skills development amongst PAMs (to staff?)
36. Consistency of leaders, who do not move jobs frequently. Covered in strategy
37. Focus on relationships with commissioners and with staff through service redesign
38. The whole service needs to work 24/7 if it is to be a truly integrated service (covered in systems)
39. People know each other, and the focus on keeping people at home is widely shared.
40. A sense of community
41. Commissioners & consultants should be encouraged work with each other (in strategy)
42. Stability of leadership - senior managers should be encouraged to remain longer in post before moving on (in strategy)
43. Stability of leadership - senior managers should be encouraged to remain longer in post before moving on (in strategy)
44. Work at relationships with the local authority and acknowledge that the local authority is a political organisation (moved to strategy)
45. Build constructive relationships with commissioners
46. Be proactive in creating the kind of future that is needed; don't wait to be pushed (moved to vision)
47. If you are older, hospitals make you ill/dependent; adopt a clear view of what hospitals do well and what they do not do well need to change things (moved to values)
48. Antagonistic relationship with PCT could be improved by trust building initiatives
49. Educate/develop high admitting GPs – not just monitoring
50. Commissioners & consultants should be encouraged work with each other

51. Hospitals need to remember that they are part of a system; you can’t just bundle an older person into a taxi (because you want the bed)
52. Focus on building relationships and supporting staff through redesign (moved to values)
53. Community trust