Appendix A

Adult ISAs

Phase 1 Consultation Feedback Document

1st October 2007 – 31st October 2007

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BACKGROUND

This paper describes the opinions voiced by staff & stakeholders during the full consultation period and the consultation events that occurred on the 3rd & 30th of October 2007.

Information describing the consultation period and event timings were distributed to PCT / SBC staff and stakeholders by email and leaflet. This information was also placed in Adult ISA, KYIT and UP2SPEED newsletters.

All stakeholders and staff were asked to contact the project manager by telephone, letter or email if they had any comments or questions.

114 staff & stakeholders attended the arranged events during which a presentation was made describing the background to Adult Integration and those areas upon which the project board wished to consult staff.

In total, 13 working groups were formed across the 2 sessions and each group performed a SWOT analysis of the key themes of consultation: -

- That we restructure adult services to develop 4 integrated Service Areas (ISAs) across Stockton
- That each ISA is served by an integrated team of community nursing staff & social care staff
- That there is a suite of specialist services that will work across all 4 ISAs
- That each ISA and the suite of specialist services are managed by an Integrated Service Area manager (which will be a joint PCT/SBC appointment)

All feedback from the consultation events has been collated and a summary of the feedback is noted below, followed by the strength, weakness, opportunity and threat most frequently voiced across the 13 groups.

Other themes commonly voiced, or stressed as key issues, are also listed below with information on how frequently each them arose.

Appendix 1 contains a list of specific questions put forward by staff and stakeholders during the consultation period.

Appendix 2 contains a full record of the feedback including the number of groups voicing each comment.

Overall Summary of Feedback:

The proposal for Integrated Adult Services is, in essence, a positive move because of the potential to improve services for patients/clients and communication between staff. This in turn will lead to a clearer path for a patient / client to follow improving the quality of that persons journey through the service.

ISAs will lead to improved an improved skill mix and a great sharing of knowledge which will be of great benefit to all, however this must be supported by clearly defined governance arrangements, clear supervision and appraisal arrangements and the appointment of ISA managers that understand the issues of managing across two organisations.

The creation of ISAs has merit but there is concern that the suitability of buildings / IT systems to support joint working may be a weakness.

There are very strong concerns that the proposed, continued practice attachment of community nursing (felt to be vital to patients, community nursing staff and general practitioners) will not survive in ISAs.

Key themes of consultation feedback:

The most commonly voiced STRENGTH of Integrated Service Areas:

- **Efficiency**
  - A better service for clients/patients and their families
  - A client is allocated to the correct/appropriate professional earlier in pathway
  - A quicker response to patient/client

The most commonly voiced WEAKNESS of Integrated Service Areas:

- **IT Issues**
  - Insufficient computers available to each team
  - Non compatible IT system between the PCT & SBC

The most commonly voiced OPPORTUNITY of Integrated Service Areas:

- **Improved understanding of roles**
  - The creation of an improved skill mix
  - Good opportunity for identifying professional developments / joint training / wider training
  - Good opportunity for understanding other professional/specialist roles

The most commonly voiced THREAT of Integrated Service Areas:

- **Loss of specialism / Sense of isolation**
  - Loss of Identity
  - Loss of areas of specialism by being in generic teams

Other commonly voiced themes:

Frequency of theme across the 13 groups	Strengths - Themes
7+	Efficiency / better service for clients/patients / Client is allocated to correct professional earlier in pathway, quicker response to patient (10)
	Having SW/DN's in same team works well / Will make joint working easier / smoother / Better professional links (9)
	One process / pathway will be an improvement / single point of access (8)
	Communication Improved (7)
5	Sharing of skills / roles and responsibilities / knowledge (5)
	Increased seamless / streamlined service (5)
Frequency of theme across the 13 groups	**Weaknesses - Themes**
7+	Number of computers available to each team – insufficient at moment / IT issues / Non compatible IT system (PCT/SBC) (8)
5	Always defeated by lack of suitable buildings / not being in same buildings / crowding / hardware (5)
4	Locality of GPs – GP may be based in one ISA and patient address may be in another – Risk? / District Nurses / Community Matrons are practice based – others are locality based – will this create problems? / Issues traveling (4)
	Dilution of staff in small groups / loss of specialism / support (4)
	Weakness not to have OT in the ISAs / No easy access to OT service / OT being a specialist service (review rationale) (4)
Frequency of theme across the 13 groups	**Opportunities - Themes**
7+	Good opportunity for understanding other professional/specialist roles & professional developments / joint training / wider training / improved skill mix (12)
6	Streamline documentation and paperwork to save time / consistency in process & pathway between ISAs / services (6)
4	OT/IC - divide team virtually to provide to ISAs – strong links needed to borough wide services / Could we have a nominated OT to contact (for each ISA team)? (4)
	Need good access to information / especially about changes in service (4)
	Much easier access / single point of access (4)
Frequency of theme across the 13 groups	**Threats - Themes**
7+	Loss of Identity / Loss of specialism (Phys Dis / Older People etc) / Sense of isolation (7)
6	Uncertainty re: new management structure / Uncertainty re: being managed by someone from a different professional background – will they understand us?/ understand specialist services / managers managing staff from two organisations – PDPs – Supervision & Appraisal (6)
5	Always defeated by lack of suitable buildings / where are people going to be based? If not based together it will limit the strengths and opportunities of ISA / If we cannot co-locate teams – how will virtual teams work? (5)
3	Not convinced that a practice linked DN will survive in ISAs / DN – Possible delays to treatment if not located in GP practice / Communication with GP's – often via DN's (currently) / DN – need to be close to GP's – flexibility (3)

APPENDIX 1.

Questions asked during phase 1 consultation events

1) Usually larger practices in NTPCT – could they not have services attached to them?
2) Why mirror children's – why not MH model?
3) How will you assign staff to ISAs? What procedures?
4) Working conditions will differ between staff in the same team?
5) Homecare needs to reflect ISAs???
6) District Nurses / Community Matrons are practice based – others are locality based – will this create problems?
7) Buildings – where are people going to be based?
8) Uncertainty re: being managed by someone from a different professional background – will they understand us?
9) Open plan or Offices…. which is best?
10) Mental Health / LD not included in ISAs – How would they fit into these developments?
11) Could we have a nominated OT to contact (for each ISA team)?
12) SALT would like to be part of teams in ISAs?
13) Joint funding – where from?
14) Is everyone in agreement? Do staff want integration?
15) Is it all a bit vague at present?
16) Is it a takeover – favouritism?
17) Concerns regarding joint budgets – will this lead to a reduction in individual team budgets?
18) Are other councils who have integrated being looked at?
19) Will there be one referral point for both social and nursing care?
20) Where do specialist services fit within the IT system?
21) Will there be the ability to maintain competencies in specialist areas?
22) Will the service be able to meet the needs of the community?
23) How are hot spots within a locality going to be resourced from within that locality? E.g. sickness / increased client demand
24) Can it be revenue neutral?
25) Cost neutral – cost of accommodation – Is there surplus to reinvest?
26) If we cannot co-locate teams – how will virtual teams work?
27) Locality of GPs – GP may be based in one ISA and patient address may be in another – (is this a) risk?
28) Will job descriptions change i.e. Healthcare Assistants doing carer's jobs?
29) What works well now?

APPENDIX 2

Full record of comments/feedback made as part of the consultation events

Feedback collation

Beside each theme is a number in brackets. This number indicates the number of times that particular theme / field was voiced across the 13 groups

Strengths:

Efficiency / better service for clients/patients / Client is allocated to correct professional earlier in pathway, quicker response to patient (10)
Having SW/DN's in same team works well / Will make joint working easier / smoother / Better professional links (9)
One process / pathway will be an improvement / single point of access (8)
Communication Improved (7)
Sharing of skills / roles and responsibilities / knowledge (5)
Increased seamless / streamlined service (5)
Improved continuity of care (4)
Better coordination (2)
Clarifies management arrangements (2)
Adults ISAs mirror children's therefore transition with life long continuum 1
Major building developments in practices – is this part of the same strategic plan? 1
Joint education & learning 1
Practice attached staff are kept – positive 1
OT – seen as specialist teams 1
Designing according to local demographics 1
Easier access to information 1
Building on care management over last 7+yrs → moves towards integration e.g. single assessment 1
Should streamline internal referrals within teams 1
This process of consultation is facilitating sharing of knowledge i.e. finding out about other services – 1
Rosedale – Referrals from community matrons (new system) 1
We need the opportunity to review 1
Less duplication / Integrated Care Plans 1
Clients who don't currently fit criteria will get assessed 1
Generic working – HCA/HC 1
Retain specialist teams 1
Relationship with client 1
Core MDT teams 1
Avoids / reduces duplication (paperwork processes) 1
Better communication between services 1
Central service to each ISA 1
Excellent access to equipment in the home 1
Better problem solving in each ISA 1
Challenges staff to improve 1

Weaknesses:

Beside each theme is a number in brackets. This number indicates the number of times that particular theme / field was voiced across the 13 groups.

Number of computers available to each team – insufficient at moment / IT issues / Non compatible IT system (PCT/SBC) (8)
Always defeated by lack of suitable buildings / not being in same buildings / crowding / hardware (5)
Locality of GPs – GP may be based in one ISA and patient address may be in another – Risk? / District Nurses / Community Matrons are practice based – others are locality based – will this create problems? / Issues traveling (4)
Dilution of staff in small groups / loss of specialism / support (4)
Weakness not to have OT in the ISAs / No easy access to OT service / OT being a specialist service (review rationale) (4)
Different processes / policies / procedures / contracts / resource allocation / terms & conditions / Pay settlements are different for LA/NHS etc. (3)
Potential for fragmenting services & for practice to be different depending on locality / ISA / manager / professional background / That ISA managers fail to retain service connections already in place (3)
How are hot spots within a locality going to be resourced from within that locality? E.g. sickness / increased client demand / Not enough staff to implement / Inadequate nursing levels to cover sickness etc. (3)
Lack of admin support (3)
Geography vs. Practice Constituency is a major issue (3)
Community physio needs to go to Intermediate Care to access service / Physio needs to be in ISAs (3)
SALT would like to be part of teams in ISAs → needs strong links (2)
Will the service be able to meet the needs of the community / Slipping the net? (2)
Can it be revenue neutral? COST (2)
Expectations – mix / match of wants and needs that ISAs may expose 1
Possibility of increase in workload 1
Access to hospital data 1
Lack of education for stakeholders re: what our services provide 1
Fear of change / unknown 1
Potential confusion 1
Challenge to professional status 1
Resources (other than staff) – providing beds at home for terminally ill 1
Ensuring we do not lose the close working relationships in place already (throwing baby out with the bath water) 1
4 localities (+ 1 specialist) may dilute strengths of individual services 1
Loss of some existing team support 1
Day Care Centres - ensure not missed out of loop 1
Mental Health / LD not included in ISAs – How would they fit into these developments? 1
Lack of specialist resources for people with head injury / younger people 1
Lack of voluntary / not for profit market 1
Referrals to specialist services need to be well process mapped 1
Poor communication process 1
Paper chasing 1
Inappropriate use of staff 1

Expectations not appropriate 1
Will there be one referral point for both social and nursing care? 1
Trying to get people working together if they have different agendas 1
Prison healthcare not included 1
Why mirror children's – why not MH model? 1
Seamless discharge service needs re-establishing in UHNT (appropriate cover) → ISA presence in UHNT 1
How will you assign staff to ISAs? What procedures? 1
Integration with Acute Care – is this an opportunity? 1
Major building developments in practices – is this part of the same strategic plan? 1
Top-heavy management system – too hierarchical? 1

Opportunities:

Beside each theme is a number in brackets. This number indicates the number of times that particular theme / field was voiced across the 13 groups.

Good opportunity for understanding other professional/specialist roles & professional developments / joint training / wider training / improved skill mix (12)
Streamline documentation and paperwork to save time / consistency in process & pathway between ISAs / services (6)
OT/IC - divide team virtually to provide to ISAs – strong links needed to borough wide services / could we have a nominated OT to contact (for each ISA team)? (4)
Need good access to information / especially about changes in service (4)
Much easier access / single point of access (4)
Lack of connectivity regarding planned investment / Health Act flexibilities (section 31) monies to allow more creativity / new post creation (3)
Clear directories of CPNs / MH / LD to access quickly / Develop a directory of all services (2)
Tailoring to 'real' communities not localities (2)
Joint working – can build up good relationships between DN's & SW's (2)
Challenge of integrating ICT systems (2)
Need to bring SALT into specialist services at an operational level / Opportunity to develop community SALT (2)
Will need joint team building 1
Need flexibility re: GP practice attachment and ISA geographical area / Need flexible ISA managers / having a manager from a different background 1
Pay scales Holidays Terms & conditions 1
Geographically co-located 1
Stimulate voluntary / not for profit market 1
Integration with Acute Care – is this an opportunity? 1
To identify gaps in specialist services 1
Demonstrate success of integration from elsewhere → build enthusiasm / commitment 1
Major building developments in practices – is this part of the same strategic plan 1
Clusters of GPs with attached SW/DN's – meets patient populations neatly 1
May work better for GPs → MDT support service 1
Improved liaison with neighbouring authorities 1
Management needs to ensure appropriate professional leadership / governance arrangements 1
Physiotherapy should be included – should be community based and provided within the community 1
Implementation of NSF 1
Up to date guidelines policy & procedures easily accessed by all workers 1
That ISA managers appreciate the current connections within the services and continue promote these connections broadly 1
Macmillan and other small services should be part of specialist services as it is a small team and should be based together 1
Phys Dis. – need backing of variety of services such as GP practices etc. but is concerned that division may cause isolation from other residential services across authority 1
ISA manager B/G 1
Connecting with GPs and practice based commissioner's → opportunity for "marketing" 1
Feedback loops into teams / GPs etc etc. 1

Developing new services where need is identified 1
Flexibility – ISAs not seen as too rigid in terms of geography 1
Individual ISA can assess their own performances and achievements to develop services further 1
More defined management structure 1
Procurement – more certainty on budgets? 1
Common assessment framework / Information sharing 1
Input of Public Health trainers and other areas – preventative agenda 1
Improved / more training for frontline staff 1
Challenge areas that are problematic i.e. records / information / IT systems / care pathways 1
Greater awareness of client needs 1
Better opportunity for clients to express what they would like from services 1
Improve morale 1

Threats:

Beside each theme is a number in brackets. This number indicates the number of times that particular theme / field was voiced across the 13 groups.

Loss of Identity / Loss of specialism (Phys Dis / Older People etc) / Sense of isolation (7)
Uncertainty re: new management structure / Uncertainty re: being managed by someone from a different professional background – will they understand us? / understand specialist services / managers managing staff from two organisations – PDPs – Supervision & Appraisal (6)
Always defeated by lack of suitable buildings / where are people going to be based? If not based together it will limit the strengths and opportunities of ISA / If we cannot co-locate teams – how will virtual teams work? (5)
Not convinced that a practice linked DN will survive in ISAs / DN – Possible delays to treatment if not located in GP practice / Communication with GP's – often via DN's (currently) / DN – need to be close to GP's – flexibility (3)
Cost neutral? – cost of accommodation – Is there surplus to reinvest? (3)
Get clinical governance sorted / right / embedded (3)
Working conditions will differ between staff in the same team? (3)
Service standards decrease during change → managing / maintaining quality (3)
Equipment (TCES) by home postcode or GP surgery? Risk to patients / Needs to be continuous equity of service – one ISA locality should not suffer because of sickness / absence etc. **Cannot turn into postcode lottery**. (2)
Currently working with two separate computer systems NHS / RAISE / CAREFIRST needs one system (2)
Staff resistant to change (2)
Need good access to information / especially about changes in service (2)
Acute trust engagement agenda/ Managers free to shape service 1
Major building developments in practices – is this part of the same strategic plan 1
Homecare needs to reflect ISAs??? 1
Improved liaison with neighbouring authorities 1
Initial contact is 5 steps away from community nursing!! 1
Ring-fenced jobs = more candidates than vacancies – impact on those left behind? 1
Barriers not access 1
Uncertainty of the future e.g. if specialised / small services are reviewed & moved. 1
OT's not included 1
Managing links into children managed services 1
Service access criteria for other services i.e. Mental Health / LD 1
More clients – no more resources 1
Lack of support 1
Phys Dis. – need backing of variety of services such as GP practices etc. but is concerned that division may cause isolation from other residential services across authority 1
Loss of flexibility 1
Joined up training – consistency 1
Workloads – stress on staff 1
GPs views from children's services experiences 1
Conflict of interests between MDT 1
Workloads may prevent further education / training of staff 1
Lack of resources for equipment 1

Redundancies? 1
Will job descriptions change i.e. Healthcare Assistants doing carer's jobs? 1
Clients not wanting change – reluctant to accept change 1
Professional closure 1
Relationships with GPs 1
What works well now? 1
Could affect staff morale 1
Patients not wanting more people to come into their homes 1
Making changes rather than improvements 1
Clarity of existing routes into services 1
Lack of continuity 1
Staff income – practical issues 1
Working environment / parking 1
Potential staff cover issues 1

Comments:

Detail – more needed
PCT & SBC **NOT** Health & Social care
Summary –

a) Joint working arrangements working well – good foundation
b) Practice attachment = strength
c) Opportunities to be creative → design care delivery specific to communities within localities
d) Need to have robust clinical / professional support for governance
e) Streamlined services for patients

Why split Billingham from Norton?
Some potential weaknesses but not to the extent they threaten ISA progress
ISA is a positive start – if it results in true integration will present more positive opportunities
Believe ISAs are a good foundation
Think this is the right way forward for patients – but still daunting.
OT → integration a plus
Overall –
Strengths – Communication – Avoiding duplication – Working together – greater understanding – faster service – client benefits
Specialist knowledge – insufficient access to community services
Weaknesses / Threats – Infrastructure – Premises / Location / ICT – Resources – Clerical support / Funding - MH/LD – ISA manager appointments are very important
Require Joint training & team building & supervision / appraisal
Need an opportunity to review → not set in stone
Locality for District Nurses – An issue (re: GPs)

APPENDIX 3.

Further comments made in "Comment" books on event days & comments made by visit / email / telephone call / letter during consultation period:

1. A need for ISA information to be given to individual teams i.e. Billingham DNs / Norton DNs etc as due to workload unable to attend sessions
2. Concerns about opposition to OT remaining a "specialist service" – hope this does not adversely affect future working relationships
3. Referral route through 1st contact & ISA – How will this affect referrals to learning disability – Will ISAs screen LD referral?
4. Specialist Teams? – OT's are in several teams now (LD/IC/Macmillan) will they join the specialist OT team countywide?
5. Will review be put into the teams or be a specialist team together?
6. Who reviews the specialist services?
7. Do health staff have no admin staff??
8. Extra travel for clerks.
9. Moving files – big job!
10. Community physio – some is provided in the sports centers in the district for people who can get to them. No service provided for housebound people who need physio at present time. IC is picking up some of this but "just physio" patients don't sit well within the IC system and the patients don't need the care bit.
11. Is physio in the community an 'acute' need or a 'primary care' need? Who should provide this?
12. Should there be a community physio service? Should IC provide it? If so – the IT systems in the local authority would need to be changed to reflect this input as the paperwork doesn't fit if the patients get a one-off physio or OT visit but not care.
13. Admin staff / non-essential car users – If they need to travel further to their place of work? What happens if two clerks want the same area? Travel to and from work if it takes longer!
14. If we're going to do this properly let's get it right first time – not "possibly" looking at integrating OT's at some point in time.
15. 4 Review teams in new structure and only 3 review officers with part time clerks at the moment. Concerns re: what will happen?
16. How will the ISA link into other health services that work across the whole area i.e. community stroke team or with services for MND or MS or PD?
17. Re: Sensory Support services – Concern re: day-to-day management support as team manager works with people of all life stages. – Important to us as a team that we are based in a locality team. The team works throughout borough now so that role would remain the same. Social care manager with contact within CESC / children's services.
18. How will you evaluate if and / or when OT will be integrated in the MDT / Locality teams?
19. How will the response to the consultation feedback be organized? When the children's services consultation took place I am not aware that there was any feedback on specific comments.
20. How will hospital discharges be linked into community services? A smooth transfer is essential to prevent readmission.
21. There will be travel implications – some benefits in co-location, some negative due to caseload across ISA areas.

22. Lack of resources in community nursing due to 'meridian' – every problem we raise is met with 'capacity' – we feel we are under capacity and we are told we are over capacity. Hopefully the advent of ISA will help in this area using other eyes. Based on contact not quality therefore the quality care we are trying to provide falls short of the figures we are supposed to attain on a daily basis. Visits across boundaries cause mega problems as in reaching those patients we are not allowed traveling time in large quantities and are allowed only 45 minutes per day.
23. Where do resources fir? E.g. Day care / hospice?
24. Where would community stroke team sit?
25. There must be recognition of professional leadership / supervision, even if day-to-day manager is from a different profession.
26. What about patients who have chosen GP's slightly further away – does treatment go with GP ISA or home address ISA?
27. IT system – need to have access to children's IT system to ensure joined up working.
28. Could review officers from SW teams be incorporated with FNC / CHC team as "add on" to ISAs?
29. IT issues – shared data preferred in electronic system.
30. Give up the idea of local based ISAs initially – have the courage to 1 office block for 3 years – put all 4 ISA staff groups together initially and let the 27 GP practices be the local face of the service for the public – have the ISAs as the efficient "back office" as a model to gain economies of scale – give the elderly and disabled of Stockton and the staff who work with them the STATUS of investment in offices & IT systems. Don't fall into the trap of squeezing staff working with them into cheap-old-not fit for 21st Century buildings & working conditions. Make this a high profile investment strategy and be proud of it. Don't underestimate the public's desire to SEE investment in them and the staff who support them. Beware of giving Children & The children's trust the new & efficient investment in services & staff relocation facilities – But discriminate on age groups on services for the elderly – poor conditions for them and the staff that support them.
31. Please remember that throughout this restructuring process the work still has to be done – stress levels will rise.
32. Cannot conceive that this will be cost neutral – where will the trimmings be?
33. ISA's will generate more work therefore services need to be properly resourced.