

**neighbourhood  
integration  
project**



**Community**  
NETWORK

# Delivering integrated care at neighbourhood level

**Developing shared working practices**

JULY 2020

## Introduction

The COVID-19 pandemic has rapidly accelerated the integration of care in the community. The transformative potential of organisations working together at a neighbourhood level to meet local needs has never been clearer.

Before the crisis hit, the Community Network initiated a project to capture the successes and share the learning from areas where local service integration was already well underway. This briefing forms part of a series published as part of this Neighbourhood Integration Project. With funding from NHS England and Improvement, the project focuses on how long-standing local partnerships have resolved the operational challenges that so often hold back the integration agenda.

A member survey carried out by the Community Network found that the need to develop shared working practices was one of the four main barriers to more joined-up care at the local level. This briefing focuses on how organisations in Devon, Hull and Worcestershire have found ways to overcome this barrier and establish agreed ways of working across their local partnerships.

The case studies in this briefing were written before the pandemic, with all the change that has brought about, not least the move to digital ways of working. However, as the NHS faces unprecedented pressures not just to recover but reset how services are delivered, we hope they are still a timely way of sharing the practical strategies health and care organisations have already used to deliver more joined-up care.

This Community Network project is supported by NHS Providers, the NHS Confederation, the National Association of Primary Care, the Association of Directors of Adult Social Services and the Association of Ambulance Chief Executives.

## Common themes

All three case studies in this briefing faced challenges in developing shared working practices. In Hull, the challenge was to support co-location of a huge range of health and care professionals with the necessary IT governance and infrastructure. In Worcestershire, working more closely with staff in private care homes required investment in communication so that colleagues understood the pressures facing them and began to work towards explicitly shared goals. One Northern Devon found that scaling up a successful approach in Ilfracombe enabled health and social care colleagues to play a full part in delivering more integrated and holistic services.

Despite the varied challenges they faced – and the different nature of the places and populations they serve – there is much common learning that the three sites share. All had to change cultures where colleagues were used to working within well-established boundaries, asking those teams to reimagine the limits and scope of their own roles and organisations. To do this, a number of things were essential:

- **Modelling the behaviour leaders wanted to see from colleagues.** This means maintaining and/or making efforts to build strong relationships with partners across the system. It was important that relationships were strong enough to support sometimes challenging conversations, and that participants were interested in finding out about and tackling the challenges their counterparts faced.
- **Giving teams a tangible problem to solve.** These areas have found that when local teams coalesce to solve a clearly articulated local problem, it is far easier to motivate them to work together than if integration is pushed for its own sake.
- **Continuing to reinforce the shared vision.** When new partners need to be brought in, existing partners experience change, or the external policy context shifts, leaders need to communicate the benefits of the vision again and again. This might mean finding champions or ambassadors on the frontline who can help maintain energy levels and resilience.
- **Showing colleagues that you really will support them, not just telling them.** Understandably, teams can fear change, or feel that making more autonomous decisions is risky. Putting the right governance in place is important to help them feel safe. However, it's just as important to take other actions that demonstrate the commitment to supporting them in new operating models. For example, One Northern Devon's flexible £20,000 funding pot for the Flow project evidenced the trust they were putting in teams to make autonomous decisions about care.

# One Northern Devon

## Key learning

- Agree a purpose and go for it – but pace yourself so you do it in the right way, allowing time to build strong relationships.
- Before you make an intervention, talk to the people it will impact to find out whether it will really work for them.
- Value systems at every unit of measurement – don't assume that bigger is better, and support communities to identify the assets they can use to tackle local issues.
- When people understand the problems in their local communities, they want to do their bit to help – and they're often best placed to. System structures should empower them.
- Ensure that strategies for integration and public health improvement include the vital role of communities
- Make sure your team feel proud of what they have done and they will evangelise for you.

## How integrated services are being delivered

Back in 2010, Ilfracombe in North Devon (population around 12,000) was home to the ward with the lowest life expectancy in the county. Despite a number of central government initiatives and consultation exercises, citizens of Ilfracombe continued to grapple with deep-seated issues that contributed to poor health outcomes such as sub-standard housing, inadequate transport links and a reliance on low-paid and seasonal employment. Frustrated by their apparent powerlessness in the face of these long-term challenges and spurred on by the arrival of new councillors from the private sector, the town council took the initiative and wrote a ten-year strategy for their town rooted in the knowledge and experience of their local community.

The county council got behind this local strategy and supported Ilfracombe to make a submission to central government for funding from the Neighbourhood Community Budgets programme. The partners recognised that health outcomes were related to the local economy, and the local economy was reliant on the cleanliness and attractiveness of the town. This understanding of interdependency led to the creation of three workstreams: economy and employment; health and wellbeing; and place. Partners across the sectors each contributed one staff member to form an operational team. The principle was agreed that no intervention would be made without first checking it made sense with the target population.

In Ilfracombe, partners sought to develop a collaborative working culture where 'any door is the right door' – so that local people got a consistent response regardless of the public service they approached for help. For example, staff from the police, council, housing, fire and other services wore 'town team' badges, so that residents could approach any member of the town team with the expectation that the problem would be dealt with whether or not it was in the remit of their organisation. Town team radios were used to assign tasks without the need for formal referral processes.

## How shared working practice challenges were resolved

While some partners – such as the police and fire service and local council – had high levels of local autonomy, it was harder for health and social care services to change the way they worked at a town level.

The creation of One Northern Devon enabled the One Ilfracombe team to widen its approach across a larger footprint, creating a partnership that would have the teeth to make real change. The partnership brings together all parts of the NHS, councils, housing, fire and rescue, the voluntary sector, police and business representatives with the shared aim of improving quality of life in Northern Devon, protecting the natural shared environment and addressing local inequality.

The Flow and High Flow projects detailed below demonstrate how the ‘no door is the wrong door’ philosophy that began in Ilfracombe continues to influence the way the teams work across organisational boundaries to deliver services in Northern Devon.

### The Flow project

The Flow model has social prescribing principles at heart. Piloted in Barnstaple (population 30,000), it seeks to ensure that patients and service users get the non-medical support they need by empowering frontline professionals – from whichever public service – to problem solve with the person, even when this falls outside of traditional organisational boundaries. It arose in response to feedback that patients felt professionals did not take the time to understand the full range of challenges they were experiencing, in addition to their medical condition.

Professionals are now encouraged to tackle the wider determinants of the health of the person by asking them what matters to them, and working with them to draw up a plan and goals. If the person needs support that the practitioner cannot provide, there is access to a coordinator who can help them to access holistic support. The One Northern Devon partners also made a £20,000 flexible funding pot available for interventions – such as paying for a company to clear the house of someone who was hoarding, or buying a new fire for a person whose heating had been condemned by the fire service.

The High Flow project uses the same principles but focuses on the 30 most frequent service users from across the public sector partners in One Northern Devon and aims to evidence that holistic support is needed to support people with complex needs.



***I think we ought to all shine a light on the fact that we sometimes make things worse by making things so complicated.***

Katherine Allen, deputy director of strategy, Northern Devon Healthcare NHS Trust  
Andrea Beacham, programme manager, One Northern Devon

## The benefits

Staff now feel empowered to have ‘what matters’ conversations with their patients and service users, safe in the knowledge that the system will back them up. At a population level, the One Northern Devon and One Town structure makes national initiatives tangible and joined-up at a local level. During the COVID-19 pandemic, the One Community infrastructure was a fundamental part of the system response with over 1000 local volunteers being rapidly recruited and deployed to support their vulnerable neighbours to self-isolate by providing shopping and prescription pick-ups and check-in and chat phone calls. .

## Care home in-reach in Worcestershire

### Key learning

- Remember that working in an integrated way means changing a longstanding culture.
- Don't underestimate the communication needed with care homes and their staff.
- Don't expect the first iteration to be perfect – be prepared to revisit and tweak.
- Ensure that the right workforce numbers are in place before you start delivering a new programme.
- Work out what success looks like for all the different partners to understand what they need to get out of the programme.
- If you want people to engage with integration, give them a concrete problem to solve.

### How integrated services are being delivered

Faced with GP frustration at empty posts in the local community provider's neighbourhood teams, partners including the clinical commissioning group (CCG), the clinical director of Droitwich and Ombersley primary care network (PCN) and the associate director of integrated community services at Worcestershire Health and Care Trust began to look more urgently at what they could do differently to support people living in care homes. Using funding from the community provider, primary care, and the CCG, they designed a pathway which would deliver multidisciplinary care from advanced nurse practitioners (ANPs), a district nurse, a pharmacist, a GP and a health care assistant.

Previously, arrangements had varied across the patch, with GPs having to focus on reactive rather than proactive care, and no direct line of GP support for the ANPs. Now care home residents can phone into the neighbourhood team, who triage and allocate those cases across the team.



***Apple, a hugely successful business, have now produced 11 iPhone versions. They didn't give up after iPhone 2, did they? They've constantly evolved and developed.***

Rob Cunningham, associate director of integrated community services,  
Worcestershire Health and Care Trust

## How shared working practice challenges were resolved

A key challenge for the new way of working was developing relationships with care homes which are largely private businesses. The team needed to carry out a big piece of work on communication with staff in those care homes to understand the challenges they faced and the ways in which the project might be able to support them.

Information technology also presented a major barrier. Primary care used EMIS, whereas community teams used Carenotes. The community teams then adopted EVIE, which should enable the two systems to come together, but the process took time and resulted in frustration at having to enter notes twice. The team recognise that a single frictionless system will make a huge difference. At the same time, the lack of connectivity in some care homes limited the use of technology in these settings.

The project has also thrown up some unanticipated challenges. For example, the multidisciplinary approach means that care home residents may not see a GP, or may see a GP other than the one they are registered with.

A key way in which the team has overcome obstacles is to develop strong relationships, enabling transparency about the genuine challenges that all players in the system face. This fosters challenging but constructive conversations. The team has encouraged partners to see the in-reach project as a shared endeavour to improve outcomes for frail older people, in order to combat any feelings that GPs shouldn't be taking on the role of educating care home staff, or that community teams shouldn't have responsibility for assessments, which form part of the GP's QOF. There is hope that, over time, contracting arrangements will be better able to encourage this sense of shared responsibility.

In the meantime, the team has found that giving staff a clear problem to solve has encouraged them to engage with the project. A project manager, funded by the federation, has also been crucial. The team has reminded partners that only by getting care right in each part of the system and taking a more structured approach will outcomes start to improve and the workload start to decrease for those who feel most stretched. Staff development and collaboration across teams has been encouraged through GP mentorship for the senior clinical nurses.

## The benefits

Continuity of care for care home residents has improved, with families and care home staff alike feeling much more supported.

Staff have benefited from learning more about the skills that their peers can offer, and from access to dedicated professionals such as the pharmacist who can answer queries much more quickly than would previously have been possible. Although the team is still not fully staffed, the culture of shared responsibility means that staff are better supported and can feel safer making potentially difficult decisions about patients' care. The model also represents an opportunity to retain the skills of clinical staff with an interest in this area who do not wish to work full time in primary care.

The project is starting to realise benefits for the wider system, as other PCNs locally start to build on this example of good practice and develop their own areas of interest.

# The Jean Bacon Integrated Care Centre, Hull

## Key learning

- Leaders need the experience and ability to project credibility and maintain strong relationships across the system.
- Bring professionals on board so that they can help you gain credibility with their peers.
- “You can’t be precious” – instead organisations need to leave their egos at the door and allow others in.

## How integrated services are being delivered

In Hull, the CCG wanted to develop a planned anticipatory model for caring for frail patients. CCG staff asked the head of transformation to develop a clinical model that would do this (see our thematic case study on governance). The council – which is coterminous with the CCG – had earlier gifted a piece of land to the CCG, which brought with it the possibility for a new custom-built centre.

City Health Care Partnership CIC (CHCP) is now the lead provider for the resulting Jean Bishop Integrated Care Centre, which brings together a range of services to deliver a comprehensive geriatric assessment to patients who are at risk of frailty, in one day, on one site.

### The Jean Bishop Integrated Care Centre

GPs can refer patients directly to the centre. Alternatively, community teams and others identify patients and the ICC team will organise with the GP for them to come in. The process works as follows:

- GPs contact patients about the service.
- An ICC support worker visits them in their home, carrying out an assessment and seeking their permission to access their integrated care record and speak to carers, as well as finding out what they want from the process.
- Patients attend the ICC, with transport arranged if necessary, and throughout that day, receive tailored input and comprehensive geriatric assessment from a range of professionals. This can include advanced nurse practitioners, occupational therapists, physical therapists, pharmacists, geriatricians, social care, and voluntary organisations including Parkinson’s UK and Alzheimer’s UK.
- Patients can receive follow up from the local rehabilitation team or the ICC team.



## How shared working practice challenges were resolved

The team working to deliver the new clinical model faced the challenge of bringing together colleagues and working practices from acute, social and primary care in this new space, and developing IT and governance solutions to support the model.

The team established regular meetings with frailty leads at the five GP clusters in Hull, so that thinking could be shared and GPs could be brought on board. These clusters broadly reflect emerging PCNs, with the development of PCN DES service specifications further incentivising primary care to come together with colleagues in different specialisms.

They also developed a shared dataset so that the local acute trust and the community provider are able to monitor what is happening with this cohort of patients. The data is held on SystemOne as a summary document, including the personalised plan developed for the patient so that the acute trust is aware should they arrive in accident and emergency.

In order that incentives are lined up to deliver integrated care, the acute trust and CCG are developing an aligned incentive contract. This contract aims to allay any anxiety that individual providers would be at an immediate financial disadvantage due to the new way of working.

## The benefits

Bringing teams together in one location to deliver care makes attending appointments easier for patients and their carers – rather than six or seven individual appointments they come for one day, get a meal and can get transport if necessary. Staff are able to work together outside of organisational boundaries to deliver the care that patients need.

The success of the Integrated Care Centre's approach is serving as a catalyst for wider system change. As the community provider works across both Hull and surrounding East Riding, there are clear opportunities to accelerate integrated working across the area, standardise person-centred care and diversionary pathways and embrace economies of scale.



***On the border you literally drive down the street and it will have a signpost and this side's Hull and that side East Riding... communities they don't... see the difference really.***

Lesley Windass, head of transformation, Hull CCG  
Carol Waudby, chief operating officer, City Health Care Partnership CIC



# Community NETWORK

The **Community Network** is the national voice of NHS community providers, hosted by the NHS Confederation and NHS Providers. We support trusts and not-for-profit organisations providing NHS community health services to deliver high-quality care by influencing national policy development, sharing good practice, and promoting a vision of integrated care in the community.

## neighbourhood integration project

The **Neighbourhood Integration Project** is a collaboration between NHS Providers, the NHS Confederation, the National Association of Primary Care, the Association of Directors of Adult Social Services and the Association of Ambulance Chief Executives. It has been funded by NHS England and NHS Improvement.

For further information and to get in touch:

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