

**neighbourhood
integration
project**



Community
NETWORK

Delivering integrated care at neighbourhood level

Approaches to workforce

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 share the learning from areas where local service integration was already becoming a reality. 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 workforce challenges were one of four main operational barriers to neighbourhood integration. This briefing focuses on how organisations in Portsmouth, Newcastle, East Cheshire and Harrogate have found ways to overcome these challenges 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

The organisations that contributed to this briefing faced a range of different workforce challenges. Portsmouth needed to invest time in bringing organisations with different working practices together. In Harrogate, the challenge was to sustain the good practice developed during its vanguard pilot. Newcastle had to work to develop a strategy and narrative about their vision for integration that people could relate to, while in East Cheshire, the task was to translate an already agreed strategy into concrete actions.

Despite the varied challenges they faced – and the different nature of the places and populations they serve – there is much common learning on integration at the neighbourhood level across these different organisations. To make progress, partnerships needed to:

- Invest in building relationships across different organisations and sectors to agree a common vision and embed changes in behaviours and working cultures.
- Ensure teams with responsibility for leading integration had buy-in from the executive and senior leadership teams as well as the flexibility to be creative in their approach.
- Involve and engage with staff at all point in the integration journey to co-design changes in services.
- Prioritise improvements in IT, with a focus on digital ways of working alongside co-locating teams where possible to align working practices.

Integrated teams in Portsmouth

Key learning

- Leading workforce integration means personally modelling the behaviours you would like others to adopt, and maximising your visibility and engagement with the frontline teams facing the challenge of working in new ways.
- Understand and respond to the everyday pressures on your teams, but focus on a culture of shared responsibility rather than blaming other parts of the system when problems come up.
- Take time to make the case and demonstrate the tangible benefits of integration to bring staff, patients and service users with you.

How integrated services are being delivered

Several years ago, health and care leaders in Portsmouth – including Portsmouth City Council, NHS Portsmouth Clinical Commissioning Group, Solent NHS Trust, Portsmouth Hospitals NHS Trust, Portsmouth GP Alliance and local voluntary sector organisations – developed a blueprint setting out their ambition for integrated services. This Portsmouth Blueprint had at its heart the principle that first comes the person and family being cared for, then comes the team, and only after that comes the organisation.

Partners have made extensive use of co-location to bring teams together, with the chief operating officer of Solent NHS Trust (who provide community and mental health services across Portsmouth, Southampton, IOW and Hampshire) leading the charge and being first to work from within the city council's headquarters. The civic offices now accommodate community nursing and social care, the learning disability service, health visiting, 0-19 young people's services, and school nursing for the centre and south of the city. In the north, Medina House repeats a smaller version of this arrangement, with the addition of the police.



You can't say that you believe in integration and then just sit in your own headquarters.

Sarah Austin, chief operating officer, Portsmouth and commercial director, Solent NHS Trust

A variety of different models are used to integrate teams – including collaboration and partnership arrangements as well as the more formal section 75s and 113s. Even with the more formal section 75s, they are governed in a “committee in common” approach with equal voting.

How workforce challenges were resolved

Partners have taken the approach of creating teams without getting unduly hung up on contracts or finances in the first instance, focusing instead on the benefits for service users. Co-location has sped up the process of collaboration and driven more rapid service improvement. For example, the PRRT – a rehabilitation and re-ablement service which provides step-up and step-down care – is co-located at St Marys Community Hospital in the city and combines therapies and nursing with paramedics and social care. The head of the team is a physiotherapist by background. The team makes a significant difference in the city promoting Home First and keeping people independent at home, avoiding inappropriate hospital admission and promoting early supportive discharge.

The city has the benefit of being largely on one clinical system. Primary care, Solent and adult social care, along with Solent Mind, all use SystmOne. The ability to set out tasks using the system rather than traditional referrals means that communication is streamlined and the right information gets to the right people more quickly – a “gamechanger” according to the chief operating officer at Solent.

Leaders have taken the pragmatic view that while they cannot unify everything (terms and conditions from different organisations can vary within teams) that need not prevent teams coalescing around a shared goal. Across health and social care, leaders seek to model a working culture of mutual accountability, where staff see themselves as responsible for their patients and service users wherever they are in the system. Should staff occasionally slip back into their organisational silo – often driven by the high-pressured nature of their roles – leaders are proactive in modelling that the responsibility for delivering high quality health and care to local people is shared across organisations in the city.



When I'm here I work for the city, I don't just work for Solent.

Sarah Austin, chief operating officer, Portsmouth
and commercial director, Solent NHS Trust

The benefits

Many staff feel that working in an integrated team is both more effective and more enjoyable. For people with learning disabilities, integrated working has provided more holistic care rather than having to determine whether their need is for health or social care. Having integrated teams also means that people who may otherwise have struggled to manage lots of different health and care interventions from different teams can enjoy a more streamlined service, tailored to them.

Collaborative Newcastle

Key learning

- Strong working relationships are key. If you don't already have them, invest heavily to develop and maintain them.
- Develop a compelling narrative about the positive difference that change will make to bring others on board.
- Colocation and joint leadership training can encourage a collaborative working culture.

How integrated services are being delivered

Newcastle's joint system leadership focuses on delivering priorities in health and care, as well as growth and prosperity. Partners in delivering this vision for health and care include the CCG, the city council, the local acute, community, and mental health trusts and the Blue Stone consortium of voluntary organisations.

At the strategic level, the joint executive group (JEG) of leaders from across the partner organisations drives forward a plan called *Improving health, wealth and wellbeing*. The tactical joint delivery group (JDG) reports into JEG and presents it with an operational workplan for sign-off twice a year.

How workforce challenges were resolved

Health and care organisations lacked a compelling narrative explaining their vision for integration and the difference it would make that colleagues and local people could relate to.

To develop a joint brand and narrative for their work, JDG members held a workshop. The Collaborative Newcastle brand emerged from a whiteboard session and further development by representatives from health and the council. Collaborative Newcastle encompasses four priority areas for the city to work on and two ways of working and will become the public-facing brand for the work currently led by the JDG.



When I felt I had a good story about why this was important and when I could describe the change that would be made... I felt much more confident.

Martin Wilson, chair, Joint Delivery Group
and chief operating officer, Newcastle Hospitals

To further promote collaborative approaches among frontline staff, the JDG are developing a plan for a wellbeing hub on a brownfield site which would integrate four different inpatient and intermediate care teams and primary care in the same building, working as a single team. Senior teams are also being co-located in council offices – but managed by a member of staff from the hospital – to foster a sense of team across organisational boundaries.

A shared command centre for health and care in Newcastle

Newcastle has spare capacity in its nursing and residential care homes but does have issues retaining sufficient staff to work in domiciliary care. Working together effectively with social care staff can be challenging given the relatively high level of churn in their sector, compared to the more heavily professionalised NHS workforce.

The local acute trust and adult social services each have responsibility for 1400 beds. When they realised that a number of patients would potentially be using both a nursing home bed and a hospital bed, the chief operating officer of the acute trust and the director of adult social services devised a way of looking at beds across the system to establish where that overlap was.

This led to the idea of a shared command centre which would provide a whole Newcastle view of where patients are and what bottlenecks are occurring. Phase one has launched, with the eventual aim a co-located space where colleagues will be able to view data in real time, with staff across the system able to view data relevant to them on their own devices.

In response to the learning from the data, changes have already been made. One team that used to train staff in care homes now provides a rapid response service to prevent unnecessary hospital admission from care homes or accelerate hospital discharge. Through dialogue with the council, the trust also discovered that the council usually stopped paying for domiciliary care after ten days in hospital. Now when the command centre receives information that a patient with a domiciliary care package has gone into hospital, hospital staff will be made aware that they have ten days to either get the patient home on their current package of care or they will need to assess them again.

In order to foster team working and develop leaders who will have an impact system wide, the city's joint leadership programme includes participants from both statutory organisations and the voluntary sector. They work together as self-defined groups or 'quads' that each pick a theme from the JDG workplan. With the support of the JDG, they have the freedom to get things wrong – in which case the whole system benefits from the learning – or to succeed, in which case the whole system wins.

The benefits

The benefits for local people include more independence in their own home and fewer hospital admissions. As the service becomes more attractive to staff, the partners believe retention and recruitment will improve, enabling more people to have the right package of care delivered.

East Cheshire – Care Communities

Key learning

- Be bold in using new approaches to tackle challenges and make change happen.
- Focus on developing a population health management approach to integration that puts the patient at the heart of care.
- Empower staff to lead changes in their area of work to ensure everyone feels invested in the transformation effort.

How integrated services are being delivered

With people in Cheshire living for longer, as well as more people living with multiple health conditions, health and care organisations have had to evolve their practices to meet the needs of their local population. Integrated Care Partnerships (ICPs) in Cheshire bring these different organisations and services together, including East Cheshire NHS Trust (an integrated acute and community trust), East Cheshire Clinical Commissioning Group and Cheshire East Council. ‘Care communities’ are seen as the building blocks of local provision, with GP practices and primary care working together with wider health and care partners to provide a wide range of services.

How workforce challenges were resolved

East Cheshire had a community integration strategy in place for a number of years to get staff in the health, social care and primary care sector to work together to support people to live with and manage frailty and other health conditions more effectively at home. However, partners acknowledged that more progress was needed to bring this strategic vision into reality.

A discussion initiated by a local GP on the need for change turned into a pivotal moment for local services, giving partners the impetus to trial a different approach and closer collaboration with primary care. Rather than focusing on changes to structures or governance, staff at East Cheshire wanted to try a different approach. They invested time in encouraging frontline staff to develop more joined up, locally led services with the full involvement of the voluntary sector. To enable this joint working, instead of using a traditional management approach the team used coaching techniques to form relationships and get teams to work better together. The teams used an appreciative inquiry method focused on asking questions, using the available data and listening to patients to learn about their needs.

Staff were keen to tackle issues using a ‘bottom-up’ quality improvement model, with PDSA cycles led by staff and incorporating patients’ views enabling more rapid changes to be made. The team identified two prototype areas to start the work. Project groups were formed with the full support and buy-in from the executive team, and the flexibility and space to trial different initiatives. Out of this came the creation of all five care communities in East Cheshire, comprising teams of health and social care colleagues, including GPs, nurses, therapists, social workers and those working in the voluntary sector. Teams were involved in a variety of different ways to shape the changes in their roles to help develop a culture of mutual respect and openness. This included staff working together to develop a new set of values, and revising their own job descriptions to reflect the more collaborative ways of working.

The different project teams were able to share their ideas and work with the other care communities, holding roadshows and clinics out in the community to showcase these new, locally led initiatives to better meet the needs of East Cheshire's neighbourhoods.



Don't underestimate the power of relationship building. Give yourself time to be able to do this properly - good relationships take time.

Debbie Burgess, Care Community coach

The benefits

Although work is still ongoing to build these care communities, both staff and patients have welcomed the changes they have brought so far. Joint working has already improved, particularly between GP's and other professionals but also between district and practice nurses who historically worked separately. Other benefits for staff have included undertaking joint training which has helped people to understand other roles, as well as co-location, making it easier to discuss patient needs and referrals in a more timely way.

The success of this initiative is not being measured against outcomes for admissions avoidance or delayed transfers of care. It is seen as a longer-term piece of work linked to population health management and health and wellbeing, and a drive to ensure that the local population live well and live independently for longer. For patients, some benefits have already been apparent. They have commented on having greater continuity and seeing the same professionals while not being aware of the different labels of each discipline. Patients are now seeing the benefits of improved communication and less duplication, including not having to repeat their history to different health and care staff.

Advice for others

- Be open to using a quality improvement method rather than the traditional project management approach, using tools to test out what works.
- Keep communication open with staff and use a coaching approach to enable staff to come up with solutions themselves and to feel comfortable raising issues.
- Having strong leadership with the ability to be flexible and get on with things without asking for permission is key.
- Get teams to design their own job descriptions, supporting them along the way to come up with their own solutions.

Integrated services in Harrogate and Rural Alliance

Key learning

- It is important to learn lessons from national initiatives and build on them to further your local integration agenda.
- Involve staff as much as possible in finding solutions to proposed changes.
- Bringing staff together more regularly to discuss cases and patient care is hugely beneficial in improving outcomes.
- It is important to recognise the value of different skill sets when bringing professionals together to provide more integrated care.

How integrated services are being delivered

Harrogate and Rural Alliance (HARA) was launched in September 2019 to improve how community health and social care is provided for adults in the area through a stronger partnership between commissioners, healthcare providers and the local authority. These services are now linked to primary care practices with professionals like community nurses, therapists and social care practitioners working together to respond to people's needs. The five organisations who are leading this work are:

- Harrogate and District NHS Foundation Trust
- NHS Harrogate and Rural District Clinical Commissioning Group, now NHS North Yorkshire CCG
- North Yorkshire County Council
- Tees, Esk and Wear Valleys NHS Foundation Trust
- Yorkshire Health Network.

How workforce challenges were resolved

Harrogate were one of 29 vanguard sites chosen to be part of the new care model programmes in 2015. For Harrogate, the aim was for GPs, community services, hospitals, mental health and social care staff to work together to transform the way care is provided and support people to remain at home in a safe and independent way. This pilot ran for three years.

Following the completion of the vanguard programme, staff were keen to find ways to hold onto the good practice that was developed during this period. This included the introduction of new staff roles and additional posts, but also the cultural expectation that staff should work together as part of multi-disciplinary teams to deliver care in a joined-up way.

As workforce capacity was stretched, it was recognised that new ways of working were needed. Improvements were also needed in IT and estates, despite progress during the vanguard programme with the introduction of co-location, the provision of laptops and shared access to records in some services.

A programme of work was put into place to develop the operating model to enable the changes. This included new team structures to bring health and social care teams together using four

main bases. These integrated teams are managed by a locality service manager who all have a background in either health or social care. Teams are defined by a geographical area and are also linked to a primary care network. The alliance is led by a dedicated director to ensure there is clear leadership for the new operating model.

Reflecting on the vanguard work, staff expressed a desire to be involved in the next stage of the integration journey and to have more of a say in their roles and areas of work. There has been extensive engagement of staff with coproduction sessions throughout the development of the alliance to ensure that staff views are taken into account and that any changes are co-designed.



Invest time to reflect on previous experiences, sharing problems and learning from them.

Dawn Bowness, senior commissioning manager – Integration

One of the main changes was the introduction of team based daily huddles. This included a broad range of professionals from both health and social care including nursing staff, occupational therapists and staff from reablement teams. Huddles played an important role in recognising the differences in people's roles and the tasks that each discipline carried out and provided an opportunity to deal with cases in a collaborative way.

Another change linked to the new operating model was reviewing the content of the mandatory training across both health and social care. This identified the commonalities between the areas and what additional training was required, including the importance of on the job training. A workforce skills audit is now being undertaken to identify what skills are needed to deliver more integrated care.

The benefits

These changes have brought great benefits for both patients and staff. Having the huddles has focused teams on how to ensure care is centred on the patient. Referrals are handled more quickly, enabling improved outcomes in patient care and treatment. The improved communication has made it easier for patients to know who to contact. They are more likely to receive the right information and there is less duplication and visits from different professionals. Co-location, hot-desking and agile working has also contributed to more effective working practices. Staff feel they are working towards preventative, more proactive care, promoting independence as well as supporting the reduction in acute and long-stay admissions.

Advice for others

- Run pilots to test out ways of working can help partners understand how to implement change over the longer-term.
- Invest in technology to enable agile working and the sharing of records as a key enabler of improvement.
- Don't underestimate the value and the time it takes to build relationships with senior managers across organisations.



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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