Purpose, Population and Place

Practical Considerations in Designing and Building an Integrated Model of Care

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May 2018
The Advancing Quality Alliance (AQuA) was established in 2010 to improve health and care quality in North West England. Our aim is to be a trusted and respected source of quality improvement expertise for the NHS and social care system.

We work with around 70 member organisations on a long-term basis, to help build improvement capability at all levels of their workforce, develop and implement quality strategies and to address their quality priorities through our extensive range of membership offers.

These aim to address four main priorities:

1. Delivering High Quality Care
2. Supporting System Transformation
3. Delivering Person Centred Care
4. Building Capability for Improvement

Our work spans across a range people and settings, from individual staff, teams, patients and service users, to whole departments, services and systems; covering frontline clinicians and support staff, to senior leaders and Boards.

We also carry out Consultancy commissions with a range of organisations across the UK; working with them to adapt our existing offers, or to design and deliver a bespoke package of support to suit their individual needs.
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Introduction

The ‘Five Year Forward View’ described how “the traditional divide between primary care, community services, and hospitals... is increasingly a barrier to the personalised and coordinated health services patients need”. It also outlined how these boundaries could be dissolved through the creation of new models of care; based around partnerships, integration and moving away from separate hospital / out of hospital funding streams.

Subsequent NHS England publications, along with the NHS England New Care Models programme, have further developed this thinking; particularly with regard to the development of Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (described further in the next section).

Over the last six years, AQuA have worked closely with system leadership teams within a number of localities across North West England, to explore the concept of integration between health and social care. We have supported them in the design and implementation of place based models of care, that unite partner organisations and local people to collaboratively transform health and care outcomes for the population.

In this paper we:

• Share our experience of enabling behavioural change, building relationships and developing system leadership at all levels of the integrated care system
• Outline our learning and what has resonated with individuals, organisations and locality leaders in the early stages of designing integrated place based care
• Provide 12 practical suggestions as to how integrated leadership teams can approach the design and implementation of place based care, illustrated with examples of our work across the North West
• Describe our change model for place based care that enables us to work with staff and citizens at all levels of the local system.
The Case for Change

There are a number of well-rehearsed arguments for the radical transformation of health and care in England, including people’s experience of disjointed care, an increasingly elderly population with multiple co-morbidities driving demand for services, and a financial imperative to use resources effectively. It is acknowledged that this situation is unsustainable for both the NHS and social care.

In 2016, the development of STPs between the NHS and local authorities, was the first step in bringing the health and care systems together to jointly plan improvements for a defined population.

‘Refreshing NHS Plans for 2018/19’ describes how STPs will evolve into Integrated Care Systems (ICS); comprised of providers and commissioners working together across STP footprints and taking collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.

ICS’s are key to making sustainable improvements in health and care by:

1. Creating more robust cross-organisational arrangements to tackle the systemic challenges facing the NHS
2. Supporting population health management approaches that facilitate the integration of services, focused on populations that are at risk of developing acute illness and hospitalisation
3. Delivering more care through re-designed community and home-based services, including in partnership with social care, the voluntary and community sector
4. Allowing systems to take collective responsibility for financial and operational performance and health outcomes.

In practice, ICS’s are varied in terms of population size and complexity (e.g. Greater Manchester has a population of 2.7 million, compared with Blackpool and Fylde Coast’s 300,000), and will be comprised of several ‘places’ or localities. Within these there are likely to be multiple neighbourhoods, usually based around a population of 30-50,000.

In Greater Manchester, where the Health and Care Partnership fulfils the role of the STP, there are 10 localities; with populations ranging from 188,000 to 628,000, and within each locality are multiple neighbourhoods with unique characteristics. Place based models of care enable integrated health and care services to reflect local need, and acknowledge that what is right for Bury will be different to what is needed in Manchester or Bolton.

Representing Population and Place: Healthier Wigan Partnership

AQuA has worked with a number of systems to support the recruitment and appointment of an Independent Chair for place based Boards.

In the Healthier Wigan partnership, AQuA’s Chief Executive, David Fillingham, is the Independent Chair of the partnership Board.

His role is to facilitate effective collaborative working across all partners, maintain commitment to the Healthier Wigan vision, and ensure that the people of Wigan remain at the heart of its work.
AQuA’s Change Model: Supporting the Design and Development of Place Based Care

Designing and implementing place based models is part of a large-scale transformation; the work is complex and can seem overwhelming. AQuA’s position in the North West and extensive experience of helping health and care systems develop place based care, has enabled us to distil our learning into 12 practical tips for how systems can start to undertake this work.

AQuA’s unique approach to supporting systems is depicted below (Figure 1). It enables change at all levels of the local system, by helping leaders to develop the skills, behaviours, and capability to deliver transformational change for population and place.

We do this by blending system leadership skill development, organisational development methodologies, quality improvement and change management expertise with technical skills and knowledge, through a process of discovery, engagement, co-design and implementation.

Our aim is to support all those involved in system change through:

- Helping leaders to develop the skills needed to lead for place, not organisation
- Sharing knowledge and learning from other systems
- Providing the space for leaders to think differently about how care can be delivered
- Engaging the system, including patients and citizens.

Figure 1
AQuA’s Model for Supporting System Change
Shaping Leadership for Place

AQuA works with the executive leaders, or a ‘top team’ from the partner organisations within the place, to lead the system in a process of change. This involves them describing a shared vision to improve population outcomes, and committing to achieve this by working collaboratively.

The role of the system leadership teams is likely to entail:

- Exploring the pros and cons of collaboratively leading the local system
- Defining what they mean by the ‘local system’ and stating its scope or boundaries
- Developing a shared leadership vision and aim statement for their local system, and 3-4 key measures or goals
- Consider the models through which they can collaboratively lead the local system to achieve this vision, e.g. Integrated care organisations (ICOs), Local Care Organisations (LCOs), or other forms of providers working in partnership
- Committing to work together through conflict, when organisations start to understand the magnitude of some of the changes that might be involved
- Demonstrating commitment to work with partner organisations and share leadership accountability, for improved population outcomes
- Demonstrating that they have put aside institutional identity, historical disagreements and interpersonal or organisational conflicts.
Creating Direction for Place Based Care

We have tested and revised our change model in multiple localities and the creation of a Senior Change Team (SCT), tasked with creating the direction for change, has been a feature in every situation.

The SCT is comprised of very senior leaders, typically within influential roles immediately below the Board, who represent each of the core partner organisations in the system. We also advocate the SCT includes a Communication Lead as discussed below.

The SCT’s role is to take the system leaders’ vision, turn it into a high level plan, gather momentum, and set the direction of travel. This involves:

• Engaging widely with the system workforce and with local stakeholders, including elected members/politicians, STPs and national bodies who could influence the plans for accountable care (such as NHS England, NHS Improvement), and with general practitioners; demonstrating a willingness to explore new models of primary care delivery

• Keeping their executive sponsor briefed and securing the commitment of their own organisation’s Board

• Developing the place based model of care and implementation plan. This may include an outline and full business case

• Progressing necessary actions associated with the new model of care within their organisation, such as identification of services that might be managed more effectively across the system e.g. some support functions

• Ensuring that the plans are person centred, and that the voice of citizens, as well as service users, is central to these

• Identifying local assets in terms of the experience, skills and resources of the workforce and of local people, and commit to making best use of these through integrated care plans

• Active communication and marketing tailored to segments of the population, to promote the place based care model and to share news about changes as they take place. The aim is to mobilise the wider workforce and local community, and is a means of creating energy and a belief that something is happening

• Recognise the desire of the wider workforce to be engaged, and their natural concern about what changes in the design and delivery of place based care might mean for them personally.

Support for the Senior Change Team

It can be helpful for the SCT to be orientated to a number of Quality Improvement methodologies and approaches, including the theory of large scale change, complexity and change management.

It is a common pitfall to assume that the SCT will already know and trust one another and are able to work effectively together. In the same way that we advocate system leadership, development and executive coaching for the executive leads, we recommend the same for the SCT. Action learning sets work well for this group, as it gives them an opportunity to actively problem-solve in a facilitated environment.

It is worth remembering that the SCT are performing a very difficult role, as they seek to balance the dilemmas of transaction business as usual and transformation for the future. They will also be expected to coach and support their direct reports and the wider workforce, so may need development as coaches and in how to create a sustainable disseminated leadership style.
Shaping Delivery of Place Based Care

The role of clinical and care leads is to carry out the detailed design of the model of care; building on the vision, aim and outcomes developed by the system leaders.

The group are expected to work to a high level outline plan, and have a mandate from the senior leaders to work towards an outline business case or equivalent.

As a first step to fully mapping the current system and its assets (including community assets), we bring the whole system together; engaging clinicians, service managers, residents, community groups and the third sector.

Once there is a clear understanding of the current system, the delivery team go on to design the detailed model of care; considering how locality services should be designed to best meet the needs of the local population, and clearly aligning this to assets in the community.

This wide group of representatives have the lived experience of receiving or providing services, and can easily recognise opportunities for improvement through real life examples of individual residents.

AQuA have worked closely with leaders from across the Healthy Wirral locality, to help make the health and care system more visible to all partners.

Working alongside statutory services in health and care, as well as the voluntary sector, we mapped the multitude of services, assets, estate and resources available across Wirral, and used Public Health data to identify specific needs for these across the Borough.

Through this, leaders in Wirral were able to understand exactly where services were being delivered, needed most, or where they were least effective due to duplication or overlap.

Frontline staff were then able to use their in-depth knowledge of services, to work collaboratively with colleagues across the system to deliver services more effectively. This was in spite of how services had been originally commissioned.
Warrington Together

Location: Large town in Cheshire between Liverpool and Manchester

Population: 210,000

Public Services: The town is served by Warrington Borough Council and a small district general hospital. Community and Mental Health services are provided by two different providers, who each face into multiple other systems.

NHS commissioning is through NHS Warrington Clinical Commissioning Group, which covers 28 GP practices and an emergent GP Federation.

Combined, these organisations form the Warrington Together partnership, which has an independent Board and reports into the town’s Health & Wellbeing Board.

Background

The development of place based care was a key action for the Warrington Health and Wellbeing Board, in order to collaboratively address the pressures on the health and social care system; including the needs of an ageing population and a rising demand on services.

System Challenges

These themes also had to carefully navigate a number of complex factors within the system, including:

- Health providers operating across multiple places and populations
- Each statutory body being bound by their own governance
- Organisations are performance managed and regulated on the organisational performance, not how they contribute to population health and wellbeing
- There can be perverse incentives which get in the way of organisations doing the right thing
- The Council are accountable to their elected members, whereas NHS organisations account through a Board
- Leaders comment on the dilemmas and tensions of living in two worlds, transaction and transformation.

AQuA’s Role

Through our role as a trusted advisor, we helped to facilitate more effective whole system working for the Board and their various working groups. We also helped to identify and consolidate common elements of system working across a range of programmes across the town.

All of these were aligned to Borough-wide strategies, established measurable outcomes and benefits for the population, and aimed to improve quality, increase effectiveness, and establish better working practices and job satisfaction.

Establishing the Three-Tier Leadership Structure

We designed and facilitated several workshops to address each of three themes; working with the town’s statutory health and care providers, commissioners, third sector, housing and other partners.
This was based on the belief that people working across organisational boundaries create better solutions to complex questions, than those only working within their own sphere of influence.

**Working with the Partnership Board**

By working closely with Warrington Together’s Partnership Board, we helped leaders establish clear governance and leadership arrangements, as well as a number of key principles for their role in achieving transformational change.

This provided the system with a clear sense of direction for the future, as well as the influence and authority to champion change and implement the new model of care. This helped to establish strong oversight of existing work streams across finance, estates, IT, workforce, communication and engagement, and empower the Senior Change Team responsible for the implementation of the model of care.

With the Board’s approach strongly rooted in public sector values, there was also the acknowledgement that scale of transformation they were trying to achieve was of a greater magnitude than any typical project or programme. With the view that this was a whole new way of thinking and delivering care in Warrington, they established their shared vision of:

> **Together, we will enable the people of Warrington to enjoy happier and healthier lives, by transforming the way we use our collective resources.**

**Agreeing the Care Model**

Warrington Together focuses on place, prevention and how residents’ homes and wider community are important for their support network and sense of self. As such, a place based model providing more effective care, delivered by a shared workforce, as close to the person’s home as possible, will have a positive impact on their health and wellbeing.

AQuA’s support enabled the Partnership Board, Senior Change Team and Clinical Leaders Team to describe a population-based model of care which provides joined up care across organisations locally, effectively and efficiently. Combining care coordination and management, this would make better use of appropriate community and voluntary services outside of the ‘traditional’ public sector offer, to support people to remain in their own community.

**The Way Forward for Warrington**

Warrington Together are clear that to be successful in this transformation journey, intense planning and hard work needs to be devoted to cultural change and engagement, for both staff and citizens.

> “**Working with AQuA has enabled Warrington Together to develop real momentum for transformational change. We really valued their skills and expertise to bring all partners together. The key benefits of working with AQuA was their neutrality and ability to challenge our thinking.**”

**Carole Hugall**

Director of Integration, Warrington Together on behalf of system partners
12 Practical Tips for Designing and Implementing Place Based Care

Having established a three-tier leadership model and outlined the roles and expectations of each, we will now explore the 12 practical steps to designing and implementing place based models of care.
1

Have a clear vision and purpose for the change

Begin with an ambitious vision. The integration of health and care services gives a once in a lifetime opportunity to be bold and aspirational about improving health outcomes for the population.

One approach that has particularly resonated with leaders we have worked with, is the Effective Leadership Behaviours model (Welbourn and Fathers, 2012). This explains how effective leaders demonstrate courage, clarity and curiosity, and challenges leaders to focus clearly on outcomes and describe what will be different for the population.
Deeply understand the needs of the population

Most places have huge amounts of under-utilised population based data. This may include Public Health data, such as Joint Strategic Needs Assessment (JSNA), primary care/GP practice data, secondary care, housing and social care data, as well as data on the experience and expectations of local people.

Enhance this information with a deep understanding of what matters to people, which can only be done by authentically engaging with them as part of the design. Using this information will ensure that the design meets the needs of population, now and in the future.
3

Ensure population and people are represented

The population of the place should play a fundamental role when designing the system of care. In practice, this is extremely difficult, however, senior leaders should ensure that the population is represented throughout the design and build.

This can be done by supporting the recruitment of independent chairs; whose role is to facilitate effective collaborative working across all partners. They maintain the commitment to the vision and ensure that the people of the place remain at the heart of the work.

This could be through third sector involvement in the steering groups, through citizen panels, or the use of people with lived experience to advise and support population representation.
4

Make the system visible to itself

Context is everything. What works in Canterbury, New Zealand may not work for inner city Manchester; although the principles may still apply the practical application may differ. The specific needs of the population, its physical assets, geography and demographics, mean that the model of care cannot necessarily be replicated from elsewhere.

By making the system visible to itself, including mapping all the assets of the place, both statutory and voluntary or community, system leaders can better understand how the locality model could maximise opportunities to deliver care differently and more effectively.

Understanding what makes place based care different from the current way of working, allows them to surface and discuss the challenges commissioners and providers are facing, for example; delivering care into multiple places, competing statutory obligations, regulations and perverse incentives. Do not let these things get in the way.
With place based care, there are often many leaders involved in designing the model of care. Each has their own agenda, statutory obligations and organisational priorities that need to be represented and delivered. This is where AQuA's role can be crucial in enabling the system architects to work together.

Often, we play a neutral ‘trusted advisor’ role in the system; facilitating stakeholders to come together and aligning them to the vision for place. We work with them to develop and understand their common purpose, and to develop a strong narrative for place. We support them to develop a way of working, that focusses on collaboration and handles the inevitable conflict effectively. This enables the system to establish trust, across organisational boundaries and competing priorities.

Both national and international evidence on place based systems, describes trust and trusting relationships as the cornerstone of effective working.

It is fundamental to the design of effective place to allow senior leaders, managers, and clinicians the time to engage and invest in developing relationships and leadership change skills. Leading for place is different to leading an organisation, and requires a very different skill set.
Develop a clear and purposeful plan

Many of the systems that we have worked with have produced a Strategic Outline Business Case, as a way of setting out their intentions for place based care, and gaining support and permission to proceed from the wider system.

This is often the first step and will be subject to further detailed design and iteration.
Understand the system resource

A detailed understanding of spend for the population is fundamental, if the system is to utilise the resources in a more effective way. This is often where conflict can arise, as organisations negotiate and understand relative financial risk and benefit sharing.

However, this process can also highlight many opportunities to reduce duplication of services, and prevent more acute (and costly) use of services. It can also enable more effective use of assets, such as buildings and staff.

Many places are developing the concept of the ‘place based £’, to ensure consolidated budgets deliver the best value for the population.
Governance processes should describe a clearly defined, collaborative decision making and approval process.

AQuA provides a significant level of support to newly-formed place based Boards, to help them to develop a robust structure and process. Some of this work also involves enabling Board members to develop and refine collaborative leadership skills.

Our work with a number of place based systems has demonstrated the value of an independent chairperson to the governance process, and we have supported several systems with the recruitment and appointment of individuals to these roles. We have also continued to support these individuals through peer support and coaching.
Assemble a team of technical experts

There are a number of ‘experts’ whose skills are required to build the model of care. AQuA’s work with the Integrated Care Discovery Communities¹, identified the need for experts in enabling processes including Human Resources, Finance and Information Technology.

Subsequent work has highlighted that the voluntary sector, and the population themselves, should be added to that list of experts.

¹http://www.AQuAnw.nhs.uk/resources/evaluation-of-the-leading-integrated-system-level-change-programme/20804
Implementing place based care requires a strong programme management approach. Systems with a dedicated Programme Director are more likely to be successful in building their model of care. These individuals perform a strategic role in translating the vision of the system leaders into tangible action.

Programme Directors require many varied skills, including strong collaborative working, resilience, good political skills, and a sense of humour, to be able to manage the complex process of transformation.
11 Build on existing foundations of integrated neighbourhood or locality teams

Within every system AQuA has worked with, solid foundations are being laid in the form of integrated neighbourhood, multi-disciplinary or locality teams. These will invariably have different names and different staffing structures, but are effectively built around a footprint of 30-50,000 population.

These teams, often with a very strong emphasis on primary care, are the focus for the frontline delivery of health and care services for the population. One example of this is the Primary Care Home Model, developed by the National Association for Primary Care².

These teams are often comprised of individuals from a number of professions (nursing, social work, therapy and more), who traditionally have not worked together in this way. Investing in developing these teams, and in particular the leaders of these teams, can reap huge rewards.

²http://napc.co.uk/primary-care-home/
Implement a proof of concept

As with any transformational change at scale, designs often need to evolve to meet emerging circumstances; amending elements but remaining true to the original vision and purpose. Implementing place based care requires a mind-set of evolution and adaptation towards the emerging environment.

Systems which start small but aim big are more likely to succeed. Often, the systems we work with develop a proof of concept; usually with a single neighbourhood or locality. This enables them to test the principles of place based care and engage deeply with the population and stakeholders.

This, underpinned by the use of quality improvement methodology, can provide some reassurance to systems, while providing a clear evidence base for continuing. We frequently use NHS England’s ‘Leading for Large Scale Change’ model as a methodology for this process.

Summary

In summary, AQuA’s work and experience shows that there are many considerations in designing and building an integrated care model for place. We need to approach this with the intent and purpose that we would any other major transformational change.

In addition to the 12 Practical Tips described, our key learning is that you need to ensure you:

- Understand the ‘place’, its people, assets and aspirations and agree the purpose
- Build relationships across organisations and communities to shape, direct and deliver place based care.

Building on Existing Foundations of Integrated Neighbourhood or Locality Teams: AQuA Leading Integrated Teams Programme

Following work with a number of integrated teams in East Lancashire in 2016, AQuA identified a need for team leaders of newly integrated multi-disciplinary teams to develop the skills and knowledge to work in a completely different way.

In collaboration with Affina OD (formally Aston OD), we developed the ‘Leading Integrated Teams’ programme. Through a combination of practical and peer learning, this is designed to support leaders of multi-disciplinary teams to develop their role as a team leader for place, within the context of an integrated service.

Participants also undertake the ‘Affina Team Journey’; a ten-step leadership questionnaire which tracks their confidence and capability in skills such as system leadership and quality improvement over the course of the programme.

“Since embarking on the Affina Team Journey, I’ve learnt so many tools to apply in getting the very best out of my team, including myself.

“The journey is very easy to follow, and makes so much sense. I wish I could have used this in years gone by, we would have been so much more informed.”

Leading Integrated Teams participant

Further information on the Affina Team Journey can be found at www.affinaod.com