

Whole System Integrated Care Bristol workshop

Background

The Local Government Association supported by Integrating Care hosted a half day engagement workshop on 19th July 2013 at the Bristol City Hall, attended by over 30 individuals working on integrated care initiatives. The event was used as a platform to engage with these individuals, drawing on their experiences of implementing integrated care to explore how they could be best supported in their endeavours. The discussion also gave attendees the opportunity to share learning around different ways that they had managed to overcome barriers to integrated care.

Attendees were divided into 4 groups where focussed discussions took place responding to a series of questions to help inform and feed into the LGA Integrated Care Toolkit and Support programme and beyond.

Thoughts on survey findings / where are we now

- Do you agree / disagree?
- What kind of support could help us address some of the issues?

Groups were asked to consider the early results from a diagnostic survey that attendees had completed in advance of the workshop. In general, the groups identified with the results, although there was some dispute that so many felt there was a clear process in place for engaging with people in the co-design of integrated care. Each group went on to discuss some of the barriers and challenges to integrated care, and what kind of support might be needed to address these issues.

Financial barriers

- There was an agreement that being unable to attribute the costs and savings of integration is a real barrier to progress and that we need to be able to demonstrate financial value.
- However we cannot do this without looking at the impact that shifting settings of care into the community will have on the acutes.
 - Acutes are a key influencer in the pathway – how can we address this? We need to get everyone around the table and enact joint governance.
 - We need to consider how to get the transfer of funding from acutes right. Ultimately acutes will be driven by the burning platform of A&E overload / current system falling over.

Leadership

- General agreement that leadership support is really important.
- One group felt that the idea of a 'benign dictator' would offer the impetus / leap of faith needed by organisations.
- Many felt that often integrated care programmes are not cross-integrated and therefore tend to be driven by local leadership.
- There was a feeling that Boards are still not held to account to for delivering integration, and that leaders should be endorsing real commitment from their organisations.
- Public Health England need to be actively involved in integrated care.

Culture

- Relationships are key, we need to insist that people work together.
- Groups felt that the real issue to address in trying to take forward integrated care is the culture of organisations and ways of working.
- Typical barriers driven by the culture within the current system include: lack of capacity, averse to risk taking, complexity, professional boundaries.
- Need to create a culture of resolutions with a focus on wellbeing: winning hearts and minds at practitioner level to enable success.
 - Could personal budgets be used as a lever to address this?

Organisational boundaries

- The 'whole system' reaches beyond health and social care, and the voluntary sector has a key role to play in this.
- Statutory boundaries are still an issue for leading and driving the health and wellbeing agenda.
- There is a clear need for cross-organisational alignment of purpose, making sure that integrated care is given the same level of priority by all – a sole agenda on the table. One group felt that in some organisations there is a lack of will and it will require determination and guts to resolve this.
- Similarly, priority needs to be supported by aligned timescales.
- There is a reluctance to make changes to workforce, e.g. management costs disincentivise change.
- In terms of involving acutes, integration is not just about the front door and exit, but about what happens inside. Does the existence of specialisms create fragmentation within organisations?

Round table discussion

Each group tackled one of three questions over an hour long discussion to help build an overall picture of the support required for different audiences and appropriate format, the tools necessary to overcome some of the barriers to integrated care that the attendees are currently facing, and the information requirements to underpin both of these forms of support.

Question 1

What will make a good value case?

- **Who are the audiences?**
- **What do they need to see?**
- In terms of audience, we need to make use of infrastructure already in place, including existing groups. Main audience categories would be:
 - a. Public
 - b. Leaders of organisations
 - c. Implementers
 - d. Providers
 - e. Organisations not involved in health but around the edges, e.g. businesses, media
 - f. Politicians (need to be held to account but not picked off)
- Need to both articulate a vision and demonstrate the benefits to secure buy-in from community.

- Audiences will want to know “What’s in it for me?” Overriding answer should be: better quality, better access, front line empowerment. Focus on what the operational benefits are for everyone. Better quality in terms of pathway / how you get there, value, lifestyles, job satisfaction etc.
- We need coherent and detailed narratives to explain and describe the change – what can people do? Noting that everyone will have to behave differently, not any one part of the system.
- GPs especially need to see what is in it for them.
- There is a specific need to engage acute Trusts – and there are multiple audiences within each Trust.
 - This will have a profound impact – e.g. there is a more appropriate care setting for 25% emergency admissions – we need to engage acutes to make a success of integrated care, and acutes need to remain viable in an integrated care system.
- Value case should support leadership and ways of aligning ambitions across organisations.
- They should also make an investment case for the targeting the population that sit in the ‘middle risk tier’ of the risk triangle.
- Conclusion of value case needs to be non-negotiable: integrating care is the only way forward.

Question 2

What outcomes from this project would help you to take forward integration?

- What kind of barriers do you need to overcome?
- What kind of tools do you need to systemise integration?

Case for change

- Biggest barrier is commitment: we need a strong case for change to achieve this. The case for change should set out the problem clearly (using financials and future trends), align stakeholders, tell the story of the patient journey, and incorporate a matrix demonstrating the consequences of not collaborating - setting out the moral case and getting the public to hold Councils to account. It should also include a 3-5 year financial plan as the current annual budget setting cycle is too short to plan for both commissioners and providers.
- Leadership buy-in has been a barrier: we need something that sets out the reasons for integration and benefits in terms of people, decreasing costs and increasing quality.
 - Particularly pertinent in the face of local government financial pressures.
- Use the patient / service user narrative and stories to create a common identifiable language. Track their journey through the system. This will help to identify missed opportunities.

Vision

- We need to be able to articulate a clear vision for integrated care, with the core values:
 - Interventions that are timely and upstream
 - Common values and standards
- Public accept these values and professionals will put them into practice.
- Shared values will help address tension between the health and social care models – they will have to be negotiated between both parties.

Case studies

- Useful to have both positive and negative case examples, for ‘lessons learned’ opportunity.
- Demonstrate best practice when involving the public and the role of Healthwatch.
- Desire for proper documentation of what was achieved in Torbay (and other successful integration sites) at a detailed level of analysis, e.g. what exactly had to change – did they use a S75?
 - Needs to be at a level of granularity that makes assumptions and decisions transparent.
 - Also a focus on ‘where are you now?’
 - From this you would be able to build a toolkit that could be localised.
- The toolkit could be organised into subjects to manage the wealth of data out there, e.g. ‘Barriers’, ‘Organisational Culture’ etc.
- The format would need to be easy to use to ensure the toolkit is fit-for-purpose and functional. It should include both detailed case studies and generic models so that people can choose the model that is most appropriate to their locality. Use of metadata tagging to structure the content?
- The subjects covered should include process as well as activity, e.g. content on having difficult conversations etc.

Financial case

- Being unable to build a robust financial case has been a barrier. It would be good to have a tool that helps people to understand financial flows.
- A good tool might be something that links financial outcomes with service user experience, joined up information to link social value.

Other barriers / solutions

- Key barrier is breaking the idea of ‘professionalism’ and managing release of control and power that is needed to achieve this cultural shift. It will require a degree of compromise between generalists and specialists, facilitated by trust embedded into the team. Infrastructure will be needed to support this, e.g. mechanisms for sharing risks.
- Top-down and bottom-up messaging needs to be matched, and we can learn lessons from non-health and social care organisations on how to bring organisations together.
- Staff should be given the ability to change things, e.g. a cooperative model like John Lewis.
- We should use the voluntary sector to understand different existing models of patient / service user engagement.
- Need to leverage the resources in the wider community, especially for prevention. E.g. leisure services, and think about ways we can use resources ‘across the piece’.

Question 3

What are the information requirements to support you work?

- **Choose the top 3 pieces of information that would help you to change the system and through this the quality of care.**
- **How might we address current information gaps?**
- There are two types of information required to support integration work:
 - a. Personal health records
 - b. Data in terms of activity in the system
- We need to draw this out meaningfully across the system.

Linked health and social care data

- Need good data to understand what the problems are and how to fix them, what the desired outcomes are and how to know if you're achieving them.
- Need a business case for investment in data linking software, demonstrating robust benefit analysis.
- Currently there are no gaps in data. We are limited by attitude, behaviour and budgets rather than 'real' barriers. Also not an excuse to say that data may be flawed / 'wrong'.
- Facebook and Twitter show that integrated records can happen – we need to stop talking and make it happen.
- Separate systems are an issue, and a barrier to creating a single system.
- There are also issues with encryption.
- Need to use the lever of risk aversion regarding data sharing: consider benefits v. risks, informed consent etc.

Financial information requirements

- Linked data
- Eligibility (means and non-means tested)
- Regular management reports on spend
- Commonality of systems with finance component

Other information requirements

- It would be good to have more knowledge of exactly what's happening in your local area so that you can think about how this can facilitate your own piece of work, and who can test this.
- An understanding of the set of metrics required. What have other sites measured, how did they measure these variables, what assumptions were made?
- Key things to know:
 - What, from an individual perspective, are the costs of accessing services both now and when they are integrated.
 - Need a balanced image of the whole system to illustrate win:win:win.
 - Single point of access to health and social care.

Expert panel concluding remarks

An expert panel provided feedback on what they had heard during the round table discussions and answered attendees' questions based on their own experience. The panel consisted of:

- Peter Colclough, Former CEO Torbay Care Trust / Director of Adult Social Services for Torbay
- Tom Shakespeare, LGA Advisor
- Simon Morioka, Director, Integrating Care
- Bruce Finnamore, Director, Integrating Care

The panel then provided their concluding remarks:

- We need to make integration mainstream: the whole system moving towards integrated care at scale and pace.
- Need to make sure that everyone has shared vision, information, funding etc. – so that they are on the same page with the brilliant outcomes! All stakeholders need to make the journey.

- There is a set of principles emerging from today's workshop and some good examples of best practice across the country.
 - MDT a prerequisite but will need to be localised.
- 'Just do it': get people to agree what they can do today, rather than waiting for central solutions.
 - Information sharing to be maximised with user / patient agreement.
- Compelling case for change, need a value case:
 - Why should I?
 - What's in it for me?
 - How will I cope?
 - How will I make it happen?
- Use Mrs Smith to 'bind us together' and both communicate and achieve the common purpose.