Sharing the biscuits: lessons from Harrogate’s new care model vanguard experience

February 2018
Foreword

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As the new care model programme comes to a close, it is important that we pause and take stock on our experiences over the last 3 years and capture the learning from as many people as possible. This legacy from the programme provides the foundation for continuing to develop and deliver a person-centred, integrated care model for people in Harrogate.

The vision has remained the same throughout the What Matters to Us programme, and still holds true: the need to work together in the best interests of the person, in a joined up and coordinated way that makes sense to people receiving the care; to keep people in the community, prevent problems occurring in the first place by being more proactive in our approach; and being quick to respond in times of crisis. This is the vision we need to keep holding onto.

My test, as a GP, was whether the new care model would make it quicker and easier to continue to support someone at home, rather than admitting them to hospital. Well, for some GPs it became a reality, but for most (and currently for all) it is still easier to admit someone. However, we have seen some real successes with GPs working as part of a community multi-disciplinary and multi-agency team to stabilise the care of people with very complex needs and achieve a much better, planned approach to care that allows people to get on with their lives. We have learnt much but there is still more to do.

Why share the biscuits?

Throughout the programme, there’s been a strong sense that to work together, as a single entity, staff need to be co-located. In recent months, towards the tail-end of the programme, our work developing a ‘pop-up’ organisation has confirmed that this sense was right. When people work alongside one another, metaphorically (and literally) sharing the team biscuit tin, they come together as a team and their allegiance shifts from the organisation that pays their salary, to the integrated team focused on achieving the best outcomes for local people. Boundaries between organisations and professional groups truly dissolve and we witness a single team, operating as one. Sharing the biscuits became shorthand for successful integration.

However, biscuits aren’t the be-all and end-all, metaphorically or otherwise. Throughout this report, you’ll read the stories of what worked and what didn’t as we tried to build a seamless service. We set out the sort of support and leadership that’s needed to create successful integrated teams. Whilst biscuits help a great deal, leaving a group of disparate staff from different organisational backgrounds and professions alone with a packet of Hobnobs, to sort it out themselves doesn’t work.

About this document

This document sets out a summary of the learning from our experience as one of the national Vanguard sites, between 2015 and 2018. As the programme to develop a new care model for Harrogate comes to an end, this is the place where our collective learning is captured. It aims to be the ‘go to’ place to find out what we aimed to do, what we achieved, what worked and what didn’t. It
will help to ensure that the successes are built on and that mistakes aren't repeated.

The document includes:

- an executive summary
- a summary of each of the main components of the care model:
  - Community Care teams
  - Intermediate care
  - Skills and workforce
  - The pop-up experiment
  - Partners experiences
  - Systems and infrastructure
  - Communications and Engagement
- recommendations to support the continuation of the journey to build the right care model for Harrogate

Finally, this document is a testament and thank you to everyone who has been involved in the programme, in particular, the frontline staff and managers who have attempted to drive over the bridge while we've been trying to build it. They have shown great resilience and commitment to improving care and continue to do so in very challenging times.

Thank you also to the people behind the scenes: project managers, business intelligence analysts, finance managers, commissioners, admin staff, minute takers, IT experts, practice managers, quality improvement and organisational development and HR specialists.
Executive Summary

Main learning points

1. Joined up, community-based care remains the right approach and the right ambition for Harrogate.
2. Mental health and social care are central to the delivery of person-centred care.
3. Unilateral planning, design and delivery by individual organisations doesn't work and undermines trust.
4. Significant and disproportionate investment in leadership is critical to successful transformational change.
5. Communication and engagement needs significant investment.
6. System and infrastructure support functions are integral to success and need to be designed in from the beginning to support the care model.
7. Managers at all levels need support to develop their skills as system leaders and to understand their role in an integrated care system.
8. Lack of attention to culture and values undermines progress.
9. Many things can be solved if the will is there and people are prepared to say ‘yes, I’ll help to find a solution’
10. Model the behaviour you expect to see.

Recommendations

1. Give your staff the tools to do their jobs
   - Training and OD to support change and emerging roles
   - A quality improvement system that supports continuous learning and improvement
   - A multi-disciplinary team that enables holistic and integrated solutions

2. Keep the person in the centre and keep it simple
   - One route in
   - One assessment
   - One plan
   - One key worker contact

3. Involve staff properly
   - Involve staff in the design and delivery, even if this means that you have to go more slowly. Time invested in this pays off.
   - Support them to get the tools of the job in place including processes and procedures: don’t expect these to materialise without help.

4. Co-locate staff
   - This is the foundation for integrated working.
   - Make sure estates and IT people are on message to support this.
   - Sweat the small stuff: make sure the wifi, access cards, IT, coffee and biscuits are all in place.

5. Centre the model on primary care
   - A connection to general practice is the common thread throughout a person’s life from birth to death. Contacts with hospitals and social care are much less common.
   - Involve GPs in daily huddles and to lead complex case discussions: solutions can be found to intractable health and wellbeing problems.

6. Leadership
   - One operational manager responsible for health and care services for the neighbourhood.
   - One person for staff to look to and get direction from.
   - Provider senior clinical leadership.
   - A cross-organisation leadership cell supporting the manager to get the job done, solving today’s problems.
Community Care Teams
What were we trying to achieve?

Develop new integrated locality teams which help prevent avoidable illness, proactively manage long term conditions and maximise functioning, and respond effectively at times of crisis and offer care closer to home.

What went well?

- The pilot team in Knaresborough/Green Hammerton/Boroughbridge had additional staff in the first four months, did not assume responsibility for urgent work, and therefore had less workload pressure. This in turn enabled regular, well-attended weekly MDTs, more collaborative working, and a responsive approach to GP queries and concerns.
- Weekly MDTs when community nurses, therapists, mental health practitioners, pharmacist, and social care staff attended were widely viewed as useful and successful.
- Having mental health practitioners, pharmacist, social care assessor, and therapists in the team on a day to day basis was seen as positive by all and led to training on basic skills across disciplines such as mental health awareness sessions.
- The Clinical Skills Trainer hired to support NCM work embraced and encouraged training across disciplines and set an example for integrated teamwork (see Skills/Workforce).
- Implementation of a System1 referral template for GPs that streamlined the referral process.

What didn’t work so well?

- We did not have the data to drive design, so the exact aims and ambitions of the CCTs and AROS were too vague to evaluate.
- There was pressure to deliver too quickly which had numerous negative impacts:
  - A lack of staff involvement in service development. For example, if we had time to listen to staff we might have avoided wholesale loss of the good aspects of the FAST team while creating AROS.
  - A lack of preparation for new roles and developing new processes to support new ways of working. For example, the mental health practitioners and social care staff felt like extras, not true team members. Therapists lost their sense of identity and “teamness” that they had in FAST. In addition, the concept of key worker was never implemented and a shared care plan never developed.
  - Insufficient attention to how to include specialist teams.
  - Lack of clarity regarding clinical and operational leadership for all new team members.
- Change to large geographically-based teams lost the connection to GPs, and were perceived as more impersonal to team members.
- Engagement of GPs in the process was difficult: the new care model was perceived as creating additional demand and not a solution to GP workload pressure.
- GP therefore did not have a significant role in shaping or supporting new teams. GPs were not present in weekly MDTs.
- Too much focus on the team configuration as opposed to changing interventions to achieve better patient outcomes. Just sitting together in the same building is not enough to create...
• Integrated working, joint care plans, and better outcomes.

• Workload pressures led to increasing pressure on staff to deliver large numbers of visits as quickly as possible reducing the community service to a task-based, hurried service. This led to a reduction in staff satisfaction and increasing anxiety. Workload pressures also led to inadequate time for team meetings, supervision, or training to address anxiety and staff satisfaction.

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**Do**

- Be careful of allowing the money to drive the speed of change.
- Listen carefully to staff in developing new proposals - we could have avoided losing the good parts of FAST when developing AROS.
- Listen carefully to GPs. They are the linchpin of community health care system - we lost their buy in with the loss of connection to the CCTs.

**Don’t**

- Don’t roll out too quickly
- Underestimate how much time, preparation, listening, monitoring, modification, and leadership is needed for effective change (PDCA cycle)
- Forget to use evidence (including data, observations, interviews, etc) to analyse the problem you want to solve

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**Do**

- Invest in supervision and leadership - see IRS lessons learned.
- Develop a trusted assessor model between community nurses, therapists and social care assessors - allow one professional’s assessment to support the other’s work.
- Spend the time necessary to work through core design elements such as who is the key worker, what is their role, what is a care plan.

**Don’t**

- Leave specialist nurses teams out of the vision and design.
- Transition from one type of service to another without clear communication of what it means.
- Create a new service and not address how the existing workload will be managed in the new service.
- Underestimate the organisational development support needed for staff.
Intermediate care

What were we trying to achieve?
Review intermediate care provision and access/discharge protocols as good alternatives to acute beds.
Increase access to intermediate care provision and rehabilitation beds.

What went well?

- Added six rehab beds at Station View with extra therapy support from HDFT.
- Geriatrician support to SV one half day per week.
- Weekly MDT including the therapy staff, DN, Mental Health Wellbeing Practitioner, and Social Care Assessor as well as Station View staff.
- IRS increased the # and % of beds used as Step Up because they had the time to support the assessment and transition.
- Good data collection from Station View tracking the use of the beds and resident outcomes, making analysis possible.
- Analysis showed over 70% of residents improved and went home within 25 days.
- Station View beds were a cost-effective step-down alternative to hospital and achieved good outcomes.

What didn’t work so well?

- Ripon beds were as expensive as a hospital bed so the case for continuing investment was weak.
- GPs continue to be unclear about how to access Step Up beds. The process appears cumbersome to them.
- Confusion amongst GPs and public about the definition of ‘interim’, ‘respite’ or ‘assessment’ bed and why they are means tested as opposed to rehab beds.
- District nursing capacity to support people in Station View with quite complex needs was under pressure: this created a perverse incentive of needing to delay or avoid admission to SV because of community nursing capacity when the alternative was a delayed transfer of care from hospital.
- There is no District-wide assessment of intermediate care capacity: we remain uncertain as to how many beds are needed?
- No decision was reached on services not currently commissioned e.g. for patients unable to be discharged home because they were temporarily non-weight bearing.

Do

- Improve information available to GPs regarding access to Step Up beds.
- Continue MDTs and bring back MH practitioners and social care assessors to the MDT.
- Analyse the community’s demand for what number of intermediate beds to address what needs.
- Link this work to Discharge to Assess pathways.

Don’t

- Assume we have the right number and right type of beds.
- Underestimate the value of an MDT approach to effective management of the flow through the beds with Geriatrician or GP insight and skills.
Skills and workforce

What were we trying to achieve?

Provide skills training and support to new and existing staff to support new ways of working and team building. Support first line supervisors to manage change and develop teams that incorporate staff from all partner providers. Identify the opportunities for sharing skills and/or upskilling staff to support efficient delivery of services and avoid duplication across providers, using the Calderdale Framework process to uncover the areas to focus.

What went well?

- Strong participation in the Calderdale Service Analysis and Task Analysis activities creating a detailed data base of information for future use
- The Clinical Skills Trainer (nurse) recruited by HDFT to support the integrated community teams embraced the learning and skills offered by other partners and disciplines such as the MH practitioners and pharmacist making them feel included and important, and offering low level nursing skills training to them.
- Willingness from staff to look at their roles and share skills, ideas
- Staff from HDFT, NYCC and TEWV proved to be resilient as they went through numerous and sometimes unclear changes in their role.

What didn’t work so well?

- There was no clarity on management responsibility within an integrated delivery model. Co-location of staff improved communication, however staff were confused about who was in charge, who to inform if they were not available to the team, where to go if they had an operational problem.
- Co-locating teams accomplishes some improved cooperation and communication, but the expectations of the CCT leaders to manage the inclusion of mental health and social care staff was not clear. MH and social care staff often felt like visitors, not team members.
- There was not enough investment in organisational development to support practice and cultural changes necessary to support integrated working
- When NCM funding was much less than expected for 2016/17, the funding to backfill positions allowing the space and time needed to support organisational development and change management disappeared. This left this work as additional to the day job for leaders, trainers, and trainees. As a result the integrated working achieved was limited to weekly MDTs for the most part, as well as the work of the Clinical Skills Trainer.

Do

- Work out the service delivery model first based on data and evidence, then work out the roles and skills to support that model.
- Invest in the organisational development expertise and capacity to embed the changes needed from Senior Execs to the front line.
- Mandate HR Directors to develop a whole system workforce strategy to enable long-term planning.
- Invest in front-line leadership working across the system.

Don’t

- Put front line staff in a room and expect them to work out process, accountability, clinical governance, supervisory relationships, etc. on their own.
- Expect that significant organisational change can happen without dedicated OD programme support.
Integrated Response Service - pop-up experiment

What were we trying to achieve?

Genuine integration of mental health, social care, primary care and community health services focussed on outcomes for people. Strengthened leadership, organisational development, workforce development and business change support. New approach designed by the staff. To test something radically different over a limited period of time.

What went well?

- Designing the service from the ‘bottom up’ and using standard work processes. Staff at all grades felt empowered.
- GP and GP practice manager involvement in service design and development
- Using a structured, evidence-based approach to service development and quality improvement
- Structured daily conversation (huddle), across a range of professionals about care delivery, allowing more time for the complex cases. This led to more timely interventions for people.
- Daily contact and joint visits between GPs, pharmacy, community physical nursing, mental health nursing, social care assessors, physiotherapy and support staff.
- Enhanced leadership model that enabled staff to get on with their role and not be constrained by organisational blocks to joint working. Frequent leadership meetings also led to the development of new and stronger relationships between front line managers from different organisations.
- Co-located in one base with access to each organisation’s electronic records
- Use of one primary system to record a person’s care from assessment, care plan and sustainability planning.
- A person-centred approach to identifying needs and intervention goals, rather than care organised around professional or organisational needs
- Building in clinical and operational supervision for all as a ‘must do’. This encouraged sharing skills and knowledge across professionals
- Teamwork/Inclusiveness - “The level of cooperation, the commitment to improvement and the willingness to listen to one another created an atmosphere that allowed everyone to have a voice.”
- Complex case discussions with GP leadership
- Helping patients to see their mental health, social care and health problems as inter-related issues and so take steps to help themselves understanding they will have multiple benefits
- Living Well staff were present daily, eager and willing contributors, and picked up many of the IRS patients at or before discharge
- Excellent PMO support for move to Jesmond House, which overcame resistance to the move
- Excellent patient feedback
- Good GP feedback

What didn’t work so well?

- Time constraint for the pilot (initially 12 weeks to design, implement and test) resulted in some of the early development and standard work taking longer to refine and embed as it felt rushed.
- The initial team base was not suitable and therefore required a move mid-way through the pilot which was disruptive.
- The generic assessment was difficult to embed due to a radical way of working and having to quickly gain confidence and learn to trust the different professionals’ initial judgement.
- Lack of effective administration support built in from the beginning due to the role being undefined
- Available skill mix from each of the partners was given to what was on offer as opposed to what was needed therefore unbalanced skill mix in the service i.e.: needed more therapy capacity.
- Lack of senior clinical leadership (i.e.: Specialist Consultant access)
- The time it took for GP to inpatient services to view one person’s records in the chosen electronic system.
- Inconsistent contact from other teams into this service.
- Did not effectively engage and involve the local Community Care Teams
- Social care assessors present for only the first two months due to workload pressure. If the IRS had
started out at Jesmond House, social care input would have been readily available throughout

- Referral rates were inconsistent leading to times when resource was underutilised and resentment from over-stressed CCTs.
- Only one therapist, left patients waiting for therapy input at times, delaying discharge
- More time to effectively embed the Agreed Action Plan template, focused and consistent documentation and focus the Daily Huddle updates on patient’s progress to goals.

Do

✓ Co-locate. The informal conversations about someone’s care are as equally important as the formal ones.
✓ Find a way to enable staff to access all systems and facilitate the quick access to necessary information that makes that prevents a person’s health and social care needs from escalating.
✓ Ensure sufficient time is given to develop standard work across agencies, with training to embed practice.
✓ Understand your demand and required skill mix prior to setting up a service
✓ Encourage joint visits as the learning from each other is invaluable in addition to the person feeling their care is joined up. It educates the individual to see their problems as a whole rather than separate parts e.g.: how a physical complaint can impact their mental wellbeing.

Don’t

✓ Design future teams without sufficient resources such as enough therapists and registered nurses to meet the challenges of annual leaves, sick leave, etc.
✓ Create rosters, work patterns and hours of operation without data to support the design
✓ Underestimate the additional management capacity required at all levels, with clear lines of accountability
✓ Underestimate the need for supervisory time to support staff to develop their role, improve their care planning skills and documentation
✓ Underestimate the power of enlisting the frontline staff in the design and development of a new service

Do

✓ Spend the time to design the service based on data/evidence as well as staff input
✓ Clarify supervisory accountability for attendance, scheduling, and the quality of documentation, as well as clinical governance
✓ Spend the time to develop and implement a true “trusted assessor” model - it is a win-win for all
✓ Devote sufficient resources to create and execute a robust communications and engagement plan for the community and staff
✓ Ensure all staff at every level, from all partners, is committed to the new way of working and share a common understanding of what is to be achieved.
The Leadership Cell is in a unique position to comment on the learning from the new care model programme and to make recommendations for the development and delivery of integrated care in Harrogate. In the last 12 months it has worked intensively as a genuine, multi-agency leadership team to enable the pop-up experiment to succeed. It met daily in the early stages of the pop-up to ensure that all that was required was put in place, and that any blocks to progress were removed. It continued to meet three times a week and then latterly on a weekly basis.

The cell developed a tangible mutual respect and trust across the partnership enabling challenging conversations to take place but always keeping the purpose at the centre to successfully solve problems. It was directly connected to frontline business and the Integrated Response Team had daily access to it to resolve team issues. It respected and acted on the concerns of the front-line. The following sets out its key messages:

**Investment in leadership is key**

IRS had much more engagement and involvement of key managers across the partners. This unblocked problems, made the staff feel more supported, enabled solving problems across organisational boundaries, built good working relationships.

A disproportionate amount of investment in leadership is necessary to enable significant service delivery changes to take place.

Leadership must operate across organisations so that staff are clear on lines of accountability.

**Data and evidence as the driver of design is a must**

Design and delivery should be based on data and monitored using informative metrics: a business intelligence analyst was required within the PMO, operating across the system.

Decisions often based on instinct rather than fact – business case was not clear enough, not based on solid analysis of the system and population needs.

Data should have included observation and listening to front line staff.

**Organisational boundaries never disappeared**

From HHTB to front line staff, everyone understood their primary responsibility was to their own organisation.

We started to improve this in the last few months, and the Provider Collaborative is showing promising signs of openness and collaboration. It took a long time to achieve this and there is a long-way to go.

Structural changes appear to be unlikely, therefore the operational implications of implementing an integrated care system need to be defined to enable integrated operational delivery to be designed, delivered and managed.

**Making staffing, service and/or design choices in isolation must be avoided**

Organisation-specific restructures and consultations were a major issue that impacted on the delivery of the new care model:

- Availability of staff
- Willingness to engage in the programme
- Anxiety about future roles and job security
- Significant loss of good will

**Admission avoidance is everyone's job**

Must view the population's needs as a whole not by organisational responsibility

An early decision made by HHTB that admission avoidance was a health function led to AROS becoming an internal HDFT service development. The model developed by IRS challenged this view and demonstrated it as a whole system issue requiring input from primary care, NYCC, HDFT and TEWV.
GP and practice manager full engagement in leading and shaping IRS in April 2017 was a turning point

GP practice management and clinical involvement improved communication and morale.

The role of the practice manager was pivotal in getting the design of the service right and critically in engaging GPs in the model. For the first time, primary care saw benefit in the new care model and their involvement created a virtuous circle in terms of learning and improvement.

Leadership – establishing accountability for delivery/outcomes

There was no clarity on who was actually accountable for service delivery and how that would function across a number of organisations. The team leader who had most staff became the de facto leader, but with no delegated authority or clarity on duties, role or function.

The learning from this was addressed in the development of the IRS experiment with clear cross-organisational leadership agreed in advance. Laying out the intentions for the programme is key.

Governance: keep it simple

The early programme had too many Task and Finish Groups without a clear enough remit. There were too many meetings, taking too much time, often with the same membership. The roles of HHTB and the Delivery Group often overlapped, compromising the Delivery Group’s remit as a programme board as its delegated authority from HHTB was not clear.

Many groups did not have authority to act, limiting them to the exchange of information and opinion but little ability to act.

Many T&F members were not able to accept responsibility to undertake work arising from the groups and acted in a representative/advisory capacity only.

Workforce Planning: joint workforce planning is needed to deliver a joined up care model

NCM was viewed as a small change at the margins, not as whole system transformation

There was no joint workforce plan. HR departments did not see NCM as a priority and continued to act in isolation.

We weren’t clear enough about why we were recruiting the various levels of staff for CCTs and AROS, Station View, Reablement etc.

Not clear enough on the implications of changing roles/services, for example, could we have modified FAST instead of undoing it all and creating AROS?

We didn’t get to grips with the capacity/demand for our services involved in the NCM – so our workforce/recruitment strategy was guesswork as well.

We didn’t follow through on the “flowopoly” initiative to fully understand the flow in and out of hospital. We never established how many intermediate beds were needed.

NCM had to prove itself financially

The business case was probably flawed and focused on securing transitional funding rather than what was achievable for the local system. The business case was based on achieving significant reductions in non-elective admissions and the ability to take costs out of the system. There was no consensus on the mechanism to achieve this.

The commissioning deficit is almost overwhelming, necessarily pulling focus from the new care model to address the financial sustainability of the whole system.

The transitional funding probably delayed us from gripping the challenges facing our system and this raised the question as to whether we would have been better off without the funding?

The transitional new care model funding and contractual negotiations became conflated and fuelled the perception that national funding allowed the commissioner to reduce the contract value. Faith in the new care model plummeted as promised investment turned to managing the establishment back to the contractual run-rate. This has probably done irreparable damage to the morale of front line staff.

The fundamental issue of understanding the capacity and demand of community services was never addressed successfully, in individual organisations or as a system.
How was it for you?: partners’ experiences

What were we trying to achieve?
To dissolve the boundaries between organisations. Partners working together to improve population health and wellbeing in Harrogate. Trusting relationships. To get the best out of the Harrogate pound.

This section reflects the main messages arising from interviews with senior leaders from across our system.

What went well?

- Working intensely together to a common purpose in delivering the pop-up model
- Learning from the process of attempting to work together has strengthened the partnership
- Great clinical staff, operating out of the same building – this has been a significant move forward with good results
- The local system has shown a willingness to try new things and stop them when they aren’t working
- More open conversations between organisations have started to happen and the elephants in the room are less hidden
- Best ideas come from the staff and it keeps them engaged
- Keep change approach worked well and produced some good tangible things to develop.

- **Clinical leadership:** not visible enough in the community. Needs to be a clinical director or geriatrician. Innovators have to be clinicians as well as managers
- **Innovation:** insufficient ability to innovate. HHTB needs to look at other areas and seek out innovation to adopt. Need to embed a continuous improvement approach
- **Trust:** poor levels of trust between organisations and reflected in managers and staff: little evidence of relinquishing autonomy or ceding control or giving up sovereignty for the benefit of the partnership
- All understand the burning platform but from their own perspectives: there isn’t a system view on this yet.
- The ground rules were unclear and open to misinterpretation - propagated mistrust
- Line management unclear: often too many voices providing advice. Staff unsure who or how to respond.
- Prevention agenda dried up and no traction gained. Some bad feeling as a result. Coincided with many challenges within system and for programme
- Communications and engagement under-resourced and poor
- Tension between Harrogate as a place and North Yorkshire as a place particularly for social care.
- **Agendas and priorities have not been adequately aligned:** little sense of shared opportunities and mutual benefits
- **Very senior people involved (HHTB and Delivery Group level)** – often don’t understand the nuances and detail and get it wrong. It also silences the people who do know and have good ideas because they are afraid to voice an opinion with senior people in the room. Disempowering as an operational manager.

What didn’t work so well?

- **Public engagement:** can’t rely on big show piece events such as the May 2015 event - it needs to be much more ingrained and far-reaching e.g. LTHFT crowd-sourced and tech-based solutions from Clever Together to seek opinion from users and staff. Sense of fear what engagement might tell us: may require us to change the plan and our behaviour. HHTB gets a sanitised/purified version which confirmed set views and doesn’t challenge.
- **Data and information:** weak and not whole system. What data there is, is not clearly understandable and digestible. Need to grip the system’s spend, outcomes, gaps.
- Delivery of vanguard felt to be in a vacuum, away from reality. The rhetoric often doesn't match the reality of service delivery.

**Do**
- Make the vision real: underpin it with a business and delivery plan setting out clearly what will be achieved by when, otherwise the perception and realisation of the vision remains different for each partner. It needs to be translated into tangible actions and delivery.
- Appoint and executive level leader on behalf of the place to drive a 10 year plan for the place, including estate, and make it happen.
- Experience other systems.
- Resolve the boundary issues up front, including practice vs geography debate, before expecting staff to operate in unclear arrangements.
- Co-locate staff.

**Don’t**
- Engagement must be built in or we will repeat the same mistakes (we risk making the same mistake with “Your Community Your Care”).
- Provider Collab: need to think about how money follows the patient as the patient leaves statutory services and out into the support of community assets otherwise rhetoric of asset-based approach will not become reality. Funding is drying up for key voluntary and community sector services.
- “Chief officers need to back off after setting the direction of travel - too intellectual and conceptual.”

**Do**
- Align the incentives: agree total system funding then allow providers to determine allocations.
- For local VCS to flourish and enable an asset-based approach they need to skills, Local infrastructure organisation required for stat sector to communicate effectively / at all with VCS. Resources, £ to support this.
- Align priorities across organisations for the system: have a purpose to work together on for mutual benefit.
- Identify tangible and achievable actions from staff and trust the front line. Keep it simple and focus on achieving the little things - not too conceptual.
- Align contractual and transformational objectives.
System and Infrastructure

What were we trying to achieve?

A locality wide shared care record accessed and updated by all partners, covered by a robust information sharing agreement. This would provide a single patient view across all systems. IT infrastructure & estates provision suitable for co-location of staff from partners including access to necessary electronic recording systems. This would support day to day operations of multi-disciplinary teams and more flexible use of estates. Data for inclusion within a range of performance and activity reports through Business Intelligence services.

What worked well?

Task & Finish group with representatives from each partner organisation worked collectively to agree and deliver solutions.

Rollout out of standard EPaCCS template using S1 to partners. The rollout is to be completed by end of March 2018.

Development of new information sharing agreement to support EPaCCS will lead to wider ISA for future joint working.

Carefully planned and executed move into Jesmond House with close support to staff.

Access to all patient record systems to support daily huddles.

What didn’t work so well?

Provision of a single shared care record not achieved due to cost and a lack of clear data & technical standards for interoperability across health and social care systems.

Availability of satisfactory estates locations to meet the needs of co-located teams was a limiting factor. Organisational estates leads were not engaged in the new care model process.

Limited co-ordination of BI provision across partners resulted in high workload on HDFT & EMBED and no real system-wide intelligence on activity or performance.

Do

✓ Co-locate staff from partners to support multi-disciplinary team working.
✓ Reciprocate Wi-Fi connectivity from different partner locations to increase opportunities for agile working and flexible use of estates.
✓ Enable access to partner care records systems to increase visibility of case recording across health and care.
✓ Have explicit information sharing protocols in place that are simple for staff to follow
✓ Agree a multi-agency estates strategy to enable co-location and better use of resources.

Don’t

✗ Introduce a single care records IT system across all partners - look to share information through interoperability solutions.
✗ Assume all estates locations are suitable for occupation by staff from multiple partners. Access, space and infrastructure need robust assessments.
Communications and engagement

What were we trying to achieve?

Comprehensive communication and engagement for all stakeholders in the programme, in particular the staff and service users.

What worked well?

- A weekly newsletter sent to all stakeholders for the first year of the programme. The newsletter set out all the developments, progress and hiccups within the programme
- The initial engagement event in May 2015, establishing the theme of ‘What matters to Us’
- A brand for the programme
- Dedicated communications capacity
- Using organisation’s AGMs to explore themes with the public such as their appetite for self-management
- Daily leadership teleconferences to establish the pop-up experiment: all partners engaged consistently with the process

What didn’t work so well?

- Partner’s organisations were unable to commit capacity from their communications and engagement resources. The new care model programme was not seen as core business and was therefore not a priority
- A dedicated communication and engagement resource within the PMO was not deemed a priority. Once that ceased, capacity and expertise was curtailed.
- Public engagement was very limited
- Engagement of the voluntary and community sector was limited and compromised by changes to way the infrastructure organisations were commissioned
- Communication with staff was very limited after the newsletter ceased. Organisations managed this in house resulting in different information being shared at different times.
- Social media (Twitter, Facebook and websites) were not invested in and usage was risk-averse
- During uncertainty around the future of the programme - which was significant in the last 12-18 months- we did not communicate enough
The recipe: recommendations from the programme

There is much learning from the last three years and this report provides a brief summary. As Harrogate moves into its version of an Integrated Care System, here are the take-home messages:

1. **Give your staff the tools to do their jobs:**
   - Training and OD to support change and emerging roles
   - A quality improvement system that supports continuous learning and improvement
   - A multi-disciplinary team that enables holistic and integrated solutions
   - Data and analytics so they know what they are dealing with and can assess their impact and adjust

2. **Keep the person in the centre and keep it simple:**
   - One route in
   - One assessment
   - One plan
   - One key worker contact

3. **Involve staff**
   - Involve staff in the design and delivery, even if this means that you have to go more slowly. Time invested in this pays off.
   - Support them to get the tools of the job in place including processes and procedures: don’t expect these to materialise without help

4. **Co-locate staff**
   - This is the foundation for integrated working.
   - Make sure estates and IT people are on message to support this.
   - Sweat the small stuff: make sure the wifi, access cards, IT, coffee and biscuits are all in place

5. **Centre the model on primary care**
   - A connection to general practice is the common thread throughout a person’s life from birth to death. Contacts with hospitals and social care are much less common.
   - Involve GPs in daily huddles and to lead complex case discussions; solutions can be found to intractable health and wellbeing problems.

6. **Leadership**
   - One operational manager responsible for health and care services for the neighbourhood.
   - One person for staff to look to and get direction from
   - Provider senior clinical leadership
   - A cross-organisation leadership cell supporting the manager to get the job done, solving today’s problems today
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