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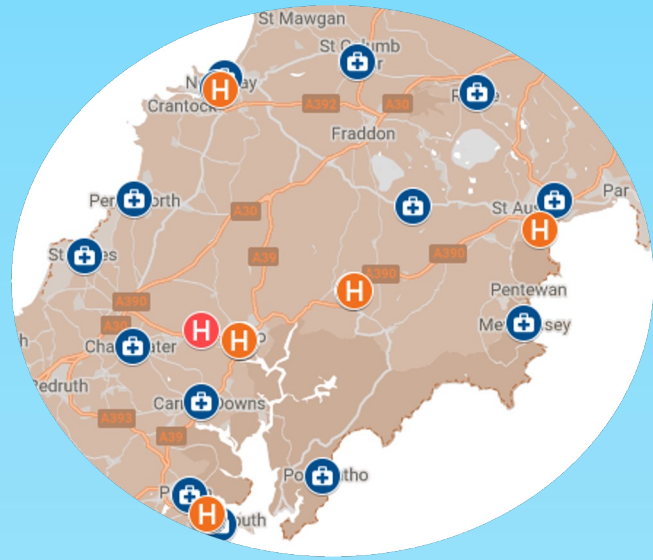

Supporting Central Cornwall Integrated Care Area to develop neighbourhood-based models of care

Proposal prepared for ICA Leadership Team

4 December 2023

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Background to the proposal

Central Cornwall is one of three Integrated Care Areas (ICAs) which make up Cornwall and Isles of Scilly Integrated Care System. Each ICA has delegated authority to develop and deliver plans to achieve the ICS's 5-year Joint Forward Plan, Integrated Care Plan and other national and system priorities.

The ICAs have a common set of shared objectives:

- Co-designed services
- One ICA budget for community health and care, based on population health needs
- Operational control of community health and care teams, functioning as one workforce
- Grow services and teams at place (PCN/ICA)
- Clear governance between ICAs and ICB
- Partners in conversations about commissioning services
- Dedicated skills, capacity and time for future planning

Central Cornwall ICA's four priorities are estates, workforce, prevention and mental health, with three underpinning principles:

- To develop a healthy population that has access to open spaces, information, exercise options and healthy foods
- Integrated operational teams
- Best use of the Central ICA £.

The ICA is led by a leadership team with senior membership across all of the key partners who are working together in the ICA.

Central Cornwall ICA sees the development of effective integrated neighbourhood teams as key to the delivery of this programme and has already made significant progress towards this goal:

- A place-based leaders workshop took place earlier this year to develop the ICA True North. Over 50 leaders from partner organisations attended. One of the key outcomes was permission for their teams to work outside organisational boundaries for the benefit of the local population
- A Central Integration Group has been established, meeting 2-3 times per year, to build cross-organisational relationships and give focus to themes such as personalisation and integration
- Community teams are already aligned to PCN areas
- The Community Gateway has been set up by more than 50 voluntary organisations to coordinate access to voluntary sector support
- The importance of co-location of teams has been recognised and premises identified for four of the six PCN areas. Challenges remain for the other two
- The ICA has developed a successful Integrated Transfer of Care Hub (IToch) which is recognised as a good example of integration
- The ICA commissioned a report on integrated working between community teams and primary care which has provided valuable insight to the experiences and challenges of the teams
- 10 Community Health and Wellbeing Workers were appointed this year to improve the ICA's ability to understand the causes of the wider determinants of inequalities and then respond to these.

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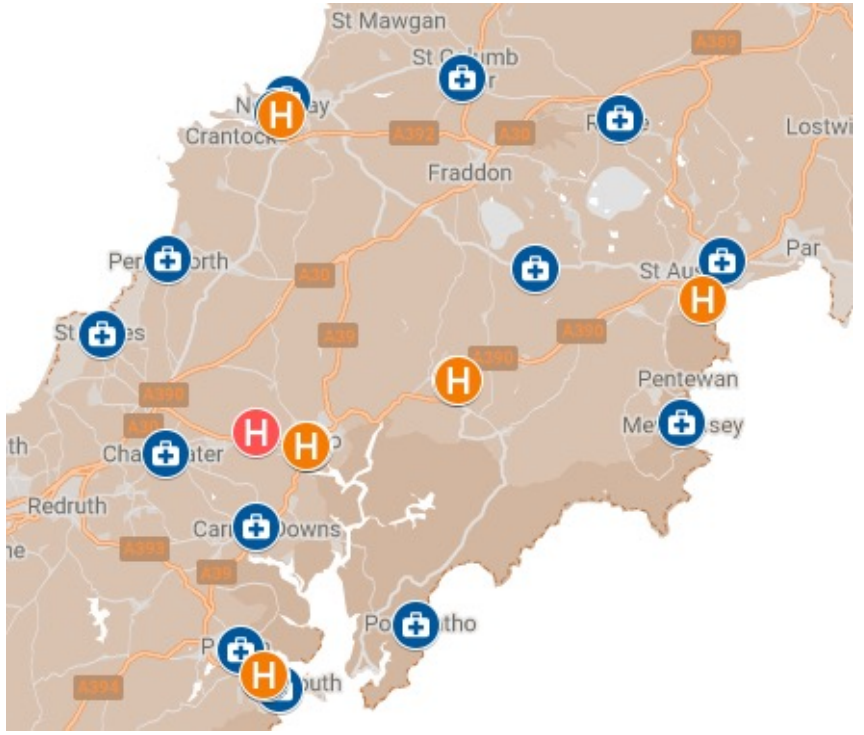
Requirements

While the ICA has laid many of the foundations for the successful development of effective neighbourhood teams at ICA level, the leadership team now wishes to shift the focus to supporting teams at neighbourhood level to move forward.

An important first step in this journey is the creation of an environment which is conducive to change and a key part of this is the existence of trusting relationships between the leaders and team members in the different partners who will be working together as a neighbourhood team, including primary care networks, community teams, mental health teams, social care and the voluntary sector.

The ICA recognises that teams will need facilitation and coaching support to develop these relationships between the local teams from all of the partners and that each team will have different needs and will be starting from different places.

In this first phase, the ICA wishes to commission this support in the emerging neighbourhood teams in three PCN areas to build the right conditions for change with a focus on the development of relationships and the building of momentum through some early successes.



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Our proposal

Our proposal focuses on facilitating **trust and stronger relationships** across three of your PCN areas and their associated neighbourhoods. Exploratory interviews will enable the NAPC team to build rapport as well as understand the key challenges to enable us to codesign the programme for each PCN area. Through a mix of workshops, one to one coaching and small group interventions we will support each neighbourhood to design immediately actionable improvement activities that **turn integrated team working into real action and impact, backed up by coaching support and regular check-ins.** This two-pronged approach to generating trust and relationships will also help gather insight into the opportunities and barriers to effective team working at the local level and help inform future phases of work.

This phase of work

Trust and stronger working relationships

- Initial exploratory interviews to facilitate relationship building and codesign of support packages, building on existing engagement work to avoid duplication of effort.
- Workshop sessions with teams in each PCN area to consider and investigate local challenges, issues, strengths and opportunities, and to build greater mutual understanding between existing team members (e.g. “A day in the life of…”)
- Assess the degree to which neighbourhoods within PCN areas self-identify as such and then deliver the required support package to further develop trust and stronger relationships

Action and impact through effective team working

- Agree with each PCN/neighbourhood team priority opportunities and challenges for rapid improvement work that will help turn integrated working into real action on the ground
- Weekly support and coaching to teams to encourage progress, identify barriers and any additional help required
- Build effective team working, trust and relationships through a structured, rapid-cycle style implementation programme
- Generate learning and insight from what doesn’t work, and celebrate and spread the things that do
- Collect trust and relationship survey data to assess progress and identify areas for further work
- Produce a wrap-up report highlighting key issues and recommendations for the next phase including the number of teams and how they align to meaningful communities

Potential future work

New models of care

- Utilise local insight and population health data to design a needs-based model of care

Workforce and team structure

- Define skills, roles and effective structure required based on population need

Corporate and clinical governance

- Consider corporate and clinical governance options and design proportionate structures

Outcome measures

- Agree process and outcome measures to monitor effective integrated team working

Digital Vanguard Programme

- Leverage the tools and assets of the SW Digital Vanguard Programme

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Proposed support plan

We suggest that there is a common, structured programme of support across all 3 PCN areas and their composite neighbourhoods to build relationships and trust and drive development at a consistent pace if possible. Exploratory interviews with senior stakeholders in the early weeks of the work will help identify challenges and opportunities at the PCN and neighbourhood levels, with further development work focused at this layer. The focus of ongoing work will be on facilitating trust and relationships at the neighbourhood level through action-orientated improvement activities that bring integrated team working to life.

December 2023

- Agree and mobilise work
- Identify stakeholders to engage in work across ICA/PCNs
- Schedu interviev worksh
- Agree support needs and priorities for 3 x PCN/neighbourhood team development programme

January 2024

- Review strategy and previous work to inform interviews
- 1:1 interviews with ICA/PCN leaders to assess current state and build relationships with NAPC team

February 2024

- Workshop 1 (PCN x 3)

Workshop 1 aims:
- Understand team hopes and fears
- "A day in the life…" group discussion
- Identify common opportunities and challenges
- Neighbourhood 4-week action plan

March 2024

- Workshop 2 (PCN x 3)

Workshop 2 aims:
- Team presentations of achievements or learning
- Reflect on what's worked, what hasn't and why?
- Next neighbourhood 4-week action plan

- Workshop 3 (PCN x 3)

Workshop 3 aims:
- Team presentations of achievements or learning
- Celebrate success
- Discuss survey findings
- Agree priorities for further work

Weekly support and encouragement calls with each neighbourhood to monitor action plans, identify support needs, escalate barriers to senior stakeholders

1:1 coaching or themed ad hoc support to key individuals/working groups supported by the wider NAPC network

Trust & relationships baseline survey → Trust & relationships follow-up survey

Regular progress reports and discussions with ICA Leadership Team on progress and learning and to unblock any barriers

Wrap up report and next steps plan

April 2024

Potential follow on work:
- Vision & ambition setting with neighbourhood teams
- Definition of the care model
- Develop integrated team structures, roles
- Agree priority outcomes and metrics
- Consider corporate and clinical governance options
- Understand the ICS/ICA "ask" in terms of permission/support required
- Leverage the SW Digital Vanguard programme

Outcomes of this work:
- Improved trust and relationships across staff groups, teams, organisations across each of the 3 PCNs and neighbourhoods
- Greater understanding of what integrated neighbourhood teams and integrated care means for each of the neighbourhoods involved
- Real action and progress made with bringing integration to life on the frontline, generating insight into what works, and barriers to effective integration
- Insight generated to guide the focus for further development work

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Why NAPC?

The National Association of Primary Care (NAPC) has led the development of neighbourhood care, population health improvement and integrated working for over two decades.

Part of this evolution was the creation of the primary care home (PCH), which informed national policy and led the transformation of integrated primary care across England. We established the framework for more personalised pro-active care and support to be provided locally that is tailored towards people's needs. St Austell was one of the Rapid Test Sites we worked with.

We are a national not-for-profit membership organisation representing and supporting the interests of professionals and organisations across the breadth of health and care.

Our range of established programmes across each integrated care system in England support and empower health and care staff to lead and pioneer change, foster innovation using digital technology and enable new ways of working to deliver integrated care through neighbourhood teams.

We deliver transformational change by working in partnership and collaboration with local systems, using local data and intelligence to design integrated care models that meet the needs of the local population and improve health and wellbeing.

NAPC support is delivered by experienced change experts who have worked within the health and care sector for many years. Our teams have first-hand experience of delivering this type of work within health and care settings in the UK and bring this experience into the support we offer.

The delivery team assigned to this programme are Jeremy Martin, Scott Maslin and Dr Johnny Marshall. Jeremy was Programme Director for the Symphony Programme national vanguard site in Somerset which introduced neighbourhood working including complex care teams and health coaches in all GP practices. Scott led a successful programme in New York focused on tackling social determinants of health and supporting the integration of health and social care services across 79 frontline teams. Dr Johnny Marshall is an experienced clinical leader with many years' experience of supporting teams through change and adopting a population health approach.

Katrina Percy and Andy Mullins will also be available to support, particularly at system level. Katrina is overall lead for neighbourhood care at NAPC. She is working with a number of systems nationally to enable the change needed to transform the model of care. Katrina had an extensive NHS career prior to joining NAPC including nearly 10 years as CEO of a community and mental health trust and leading one of the Vanguard New Models of Care Programme sites.

Andy Mullins lives within the Central Cornwall ICA and is one of NAPC's most experienced faculty members. His current focus is supporting ICS leaders to develop a common approach to delivering integrated care and implement it.

Our delivery team for this assignment

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Jeremy Martin

Facilitator and coach
NAPC Lead for this engagement

Jeremy worked in the NHS for 25 years, most recently as Director of Transformation at an acute hospital in the South West. From 2013-2019 he was the Programme Director of the Symphony Programme in Somerset - an innovative and successful national Vanguard programme developing and implementing creative approaches to integrated neighbourhood teams and population health as well as building a new business model for GP practices in the area. The programme was one of the first to develop a unified data-set, introduce health coaches in GP practices and create neighbourhood complex care teams.

Since then he has focussed on supporting organisations and systems to create successful approaches to population health and neighbourhood working and has worked with PCNs and systems across the UK. He is also an experienced executive coach.

Scott Maslin

Facilitator and coach

Scott has over 20 years of experience leading and providing expert advice on health and care system transformation and is a real-world specialist in turning policy and strategy into practical positive impact. As a former big-4 consultant and an independent advisor he has supported private sector and government clients - at local, regional and national levels - across the UK, Europe and the USA in areas such as care integration strategy and implementation, complex stakeholder engagement, policy design and rapid cycle improvement approaches.

Scott led a programme in New York focused on tackling social determinants of health and supporting the integration of health and social care services. This involved 79 frontline teams, almost 1,000 staff and 15,000 “high utiliser” patients and achieved proven reductions in ED attendances and inpatient admissions.

Dr Johnny Marshall

NAPC Clinical Faculty

Johnny is highly experienced in supporting change within the NHS, particularly through enabling local professional teams to develop their own solutions. He retired from clinical general practice in 2021 but remains passionate about incorporating a population health improvement approach to create sustainable support for individuals and communities.

During his career, Johnny has built a reputation as a trusted leader and advisor, providing valued vision and insight on health & care policy on behalf of NHS membership organisations. He has established effective partnerships at board level between NHS membership organisations and key partners including national NHS bodies, local government and professional representative groups.

Johnny is currently a member of NAPC’s senior leadership team and NAPC Clinical Lead to the CARE programme.

NAPC System Leads for this assignment

Katrina Percy

System coach and facilitator

Katrina is a member of the National Association of Primary Care Faculty and leads our work on drawing together new care models and digital transformation and supporting its delivery in health systems.

Katrina has worked across all sectors of the health service, including internationally, since joining on the NHS graduate management training scheme over 27 years ago. Katrina was an NHS CEO for nearly 10 years, winning the coveted NHS CEO of the year and being named amongst the 50 most inspirational women in healthcare. She is known for her capability to lead organisations, both big and small through transformational and innovative change including the creation of integrated primary and community care teams. More recently her focus has been on the development and successful implementation of tech and digital health solutions; integrated care model development and leadership development.

Andy Mullins

System coach and facilitator

Andy has worked with system leaders in a number of ICSs to help them to develop their thinking around integrated neighbourhood teams and align around a common approach. He has been a member of the NAPC Faculty for 8 years and lives within the Central Cornwall ICA.

Andy is an experienced facilitator, team coach and change leader. He has more than 30 years of experience facilitating change across both public, and private sectors. He works with teams, organisations and systems, to help them cut through the fog of complexity to find clarity, common ground and solutions, and to be the best they can be. His focus for the last 20 years, has been on the health sector, but also has extensive experience of working with charities, public transport and manufacturing.