Embedding Meaningful Engagement during Transformation—Community Integration

Introduction

On the Isle of Wight we have implemented an Integrated Locality model in collaboration with key partners: the Local Authority, CCG, Voluntary Sector, Police, Fire and other agencies. The aims of localities or "clusters" as defined by the Hampshire and Isle of Wight (HIOW) STP are:

For people

- ✓ Stay well (fewer exacerbations, look after own health)
- ✓ Easier access to support and advice
- ✓ Care delivered close to home
- ✓ Proactive, joined-up care delivered closer to home
- ✓ Maintain independence in usual place of residence
- ✓ Greater choice and control

For HIOW system

- ✓ Sustainable primary care
- ✓ Increased capacity in primary community and social care
- ✓ Reduction in rate of acute non-elective activity growth
- ✓ Reduction in variation in access and outcomes
- ✓ Fewer permanent admissions to residential/ nursing care
- ✓ Workforce retention

To date representation for communities has been via our Health & Well-being Town and Parish Council, who have been involved in the development of the Localities and associated projects (e.g. Community Resilience Event). We have not yet established direct routes for engagement with people. This feels like a gap; particularly when there are significant changes to how care will be delivered with increased information-sharing between professionals.

One question I wanted to test with the public in particular:

You told us you didn't want to tell your story more than once (National Voices). We believe we can do this by working in partnership with other teams and organisations. This will involve us sharing your information far more than we have done before.
Does this feel right and what do you need to know about the new ways of working?

Project Description

Through discussion with the Healthwatch IOW manager I became aware each GP practice is contractually obliged to have a Patient Participation Group. This ensures people have a say in shaping service delivery, prioritising patient safety and maintaining good quality care in general practice.

PPGs can provide broad feedback around community services and be an excellent option as a group of people to engage with. As well as accessing PPG groups we could also request representatives to attend and participate in our Locality Management Group meetings. This would provide opportunities to shape service model development and allocation of resources according to population need. We were already developing processes to gather relevant data (from PH, CCG, Service Providers) to inform these meetings. But feedback on public and patient experience was missing.

The plan was to develop a relationship with one or more PPGs in each Locality to begin our engagement journey. There were 2 options regarding access to the PPGs. One is via Healthwatch that supports a group of Independent PPG chairs. The other is via direct contact with the Practices. The intention was to do both.

We would use the PDSA methodology to develop processes for information to feed between ILS and the PPGs.

Key findings - Things don't go to plan!

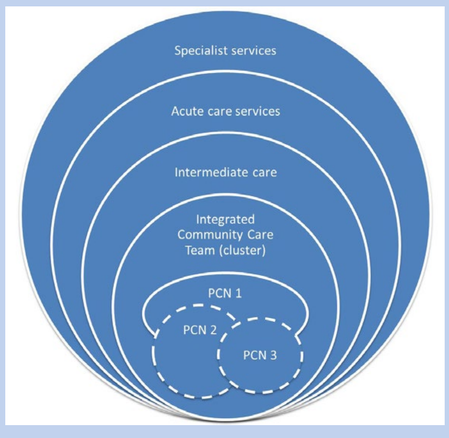
Barrier No 1 - Colleagues concerns

Some Integrated Localities colleagues were very concerned about engaging with the public when our remit was not fully defined. In particular the vision for Adult Social Care was not yet articulated. The Locality Social Workers (currently focused on complex but non-statutory preventative work) were uncomfortable engaging people when we could not answer questions regarding the ASC "offer" in Localities. This was a legitimate concern for them but not necessarily a block to engaging people. If we wait until the plan is agreed prior to engaging we are only offering consultation and not true engagement. This could be interpreted as tokenism and presents an opportunity for learning. As a team our thinking is midpoint on Arnstein's "Ladder of Citizen Participation" and a shift upwards towards true partnership in the future is needed. Thanks to the EEP course I am keen to support this.

Barrier No 2 - dramatically changing landscape

Community Transformation efforts on the IOW have mainly focused around NHS Trust Community Services, Adult Social Care and voluntary sector partners. Primary Care involvement has been limited, with little appetite to engage with Locality MDT meetings. Our ILS Coordinators have built relationships with some practice staff and agreed processes to share information. Therefore our plan has been organic relationship building. In this context I planned to approach practices generally receptive to integrated working to discuss accessing their PPG. However the dynamic has changed since the new GP contract was released with the direction to create Primary Care Networks.

Practices' focus has been on confirming their PCN, Clinical Director (CD) and working with the CCG and system leaders to agree new ways of working. In terms of developing PPE this has been "parked" in the short term until relationships/ effective dynamics have been established between myself, my Locality CD and the CCG Director for the Locality.



In the meantime I have designed a PPE model diagram to support discussions. This will be applicable for the PCN work and within the NHS Division in which I am employed. I have also been able to take the principles and influence the Division's draft PPE strategy and Staff Engagement Strategy.

Project Goals

- To identify new or existing cohorts of People the Locality could engage with
- To build relationships with groups and key individuals
- To design resources for an engagement session/ alternative methods of communication
- To find a way to engage people in service model change where transformation is not particularly visible i.e. better coordination between services (still seen by the District Nurse and a Social Worker but it should feel better; more joined up)
- To carry out first engagement session and agree ongoing processes for engagement

Evaluation - What would good look like?

- ✓ Named contacts for the Locality and PPGs
- ✓ Access agreed to the groups
- ✓ A framework for PPE in the Localities
- ✓ Public or Patient Representatives in our Locality meetings

Conclusions

I have learnt the following key things:

- I am now aware my default setting is one developed for a clinical career: to diagnose, risk assess and problem solve. I consciously have to stop myself launching into designing solutions and remember to involve people at the beginning of new projects.
- Progress isn't always linear. Flexibility is required to shift according to system opportunities and constraints. I haven't been able to implement my PPE model but am much better prepared to do it when the time is right. The PCN relationships are the current priority. This quote from Warren Heppolette, Exec lead for strategy & systems development for the Greater Manchester Health and Social Care Partnership, regarding integration equally applies to PPE:

"This doesn't work on a hierarchical governance model any more. This is about networks, it's about reciprocity, it's about humility and it can't be a planned response to a written document, it can't be a single plan. This has more of the characteristics of a movement than a simple response to a plan."

References

- National Voices (May2013) A Narrative for Person-Centred Coordinated Care
- Arnstein S., A ladder of participation. JAIP, Vol35, No. 4, July 1969, pp 216-224
- Primary Care Commissioning White Paper (June, 2019) Why we don't want to be here again: the state of integrated care Insights from the ICS Summit 2019

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