Spreading and scaling the Age UK Integrated Care model

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Overview

- The Age UK Integrated Care Model
- Spreading and scaling – the timeline and starting point
- Lessons learned

“I felt supported, I was at all sixes and sevens and there [the Independence-Coordinator] was offering me all this help, understanding, kindness and friendship. I couldn’t have done it without her; I was frightened, depressed and unwell. She treated me with respect, and that was important to me at a time when I felt like I was losing everything around me. My garden was getting overgrown and my house was a muddle, and I couldn’t get out to shop so I wasn’t eating properly. I now feel more in control, and that I have choices. She motivated me to get out. Before it was like I had a brick wall in front of me. She cracked a bit of that wall and then, with her help, I made that crack bigger and bigger until it became an open door.”

Client
01 The Age UK Integrated Care Model
An holistic social prescribing model for older people with multiple long term conditions and at risk of hospital admissions
The critical elements of the model

When combined these ‘magic ingredients’ have created a cycle of positive action that has helped older people move towards and achieve their goals for living well and added value to primary care.
02 Spreading and scaling – the timeline and starting point
Spreading and scaling the model – a learning journey focused on improving rather than proving

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- **Cornwall pathfinder and an HSJ award**
- **Phase 2 of the spread and scale commences involving 8 health and care partnerships across England**
  - Ashford and Canterbury
  - Blackburn with Darwen
  - East Lancashire
  - Guildford and Waverley
  - North Tyneside
  - Portsmouth
  - Redbridge, Barking and Havering
  - Sheffield
- **Phase 3 of the spread and scale commences involving 5 health and care partnerships across England**
  - Croydon
  - Northamptonshire
  - North Kent
  - South Kent
  - South Gloucestershire
The starting point for spreading and scaling the model

- **evidence** from the Cornwall pathfinder, a national platform and lots of **interest** in testing the model – driven by national and local levers

- **an offer and credibility:**
  - Funding (and a requirement that local health and care partnerships would provide match funding)
  - Programme management support, lessons learned and tools
  - A partner network of local Age UKs
  - Independent evaluation at a national and local level
  - A commitment to sharing IP and lessons learned in the interest of improving outcomes for older people
  - Strategic partnerships (e.g. with the AHSN)

- **An application process** to help to identify where best to spread and scale the model
It’s about being adaptable rather replicable and flexible rather than rigid

- The phased approach built-in the flexibility to respond to learning on the ground and the changing local and national contexts
- A structured co-design phase in each new site has ensured that those adopting the model shape and adapt its design to the local context
- A focus on core principles rather than a fixed model can help manage the tension between adaptability, flexibility and fidelity
- Pragmatism will be necessary in the interest of making the partnership successful
- Recognise that every new partnership has to ‘touch and learn for themselves’

“At first it seemed a little prescriptive, but Age UK listened to us and what we thought was needed. They were flexible about changing the criteria after implementation – we had the debate with all the partners at national level. The flexibility on the criteria improved our relationships with the practices.”
Adaptability and flexibility continues beyond co-design – time and effort is needed to stabilise the model in a new patch

- It’s not a case of build it, it will work and they will come
- The model will continue to develop as it unfolds on ‘new’ ground – embracing a test, learn and adapt approach is critical
- Creating momentum locally involves building and strengthening relationships, trust and credibility and understanding of the model’s value at all levels
- More than 12 months is needed understand whether and how the model works in a new patch, and to really embed it

“We were as ready as we were ever going to be to go live. A year’s operation isn’t really enough time to iron out things on the ground when you actually start to deliver the service. It takes time to build relationships and ways of working between GPs, other healthcare professionals and the VCS – we aren’t used to working with each other in this way. It takes two or three months to get staff really confident and trained.”
Creating opportunities for reflective learning and strong feedback loops have been crucial to success

National monthly learning forums

- Space for those involved in spreading the model to share knowledge, challenges and effective practice

- Initially for team leaders/senior managers from across the sites, with additional forums established for Independence Co-ordinators in Phase 3

- Supported timely collective problem solving and has enabled a more agile approach to optimising aspects of the model at a local and programme level

“The learning forums were great, especially if you are willing to learn from each other. [The chairperson] really pulled out the detail. It’s always good to know you are not the only one in a boat with a hole in it. Or to learn about things and think, ‘Why can’t we do that?’ It might turn out you can’t, or you end up putting another bell and whistle on it and you go back to the forum and share it.”
Encourage a collaborative approach at all levels to avoid dependency on one organisation or one individual

A key enabler has been the joint approach to the day-to-day strategic and operational management of the spread of the model at a local level:

- Partnership between a senior programme manager from the local Age UK and senior manager from the CCG

- Blends the skills, expertise and experience in
  - the needs, ways of working and cultures of various partners and stakeholders
  - engaging effectively and navigating the different parts of system
  - influencing others to co-produce and co-deliver change

- CCG programme manager role funded by Age UK and requires committed capacity – it’s not to be tagged onto the day job
Multiple factors help create the conditions to support sustainability

- A shared understanding of the evidence needed to understand impact from the outset
- …and then capturing that evidence and using it along the way (not just at the end)
  - No escaping the need to evidence value for money, including any cost efficiencies associated with shifts in care, if the model is to be adopted
  - Personal stories of need, impact and how the model has brought about change are powerful in winning hearts and minds
- Strong relationships, partnerships and flexibility to adapt the model are also critical

“While patient stories and the WEMWEBS are really important and valuable, it does come down to the quantitative data to make tough decisions in a climate of financial pressure. It’s about evidencing the value for money and return on investment, how it fits with wider plans, if it’s economically making a difference.”
The pathway to sustainability has varied

- For most sites there hasn’t been a seamless transition from ‘test/pilot’ to a commissioned

- The paths have varied:
  - Short-term commissioning (6 – 12 month) followed by longer-term contracts (2 – 3 years) with the local CCG
  - Drawing on alternative funding routes (in addition to or instead of the CCG)
  - Partnering with other VCS services to respond to local needs

The need for ongoing adaptability will continue – keep an open mind about what successful sustainability might look like and stay alert to opportunities that might be around the corner ….. and who can help
The VCS plays an important role in spreading and scaling change

- Provides skin in the game
  - flexible nature of its funding can stimulate the spread of innovations
  - Age UK funding has provided ‘pump priming’ for localities to adopt the model and to maintain equitable partnerships

- Brings an independent voice – and a system-wide view of older people’s perspective of what’s working and what isn’t.
  - Enables the VCS to act as a neutral agent to convene people and organisations within systems, and to provide healthy challenge
  - Maintains a focus on, a shared purpose centred on helping older people live well

“The flexibility, and how they are able to innovate and flex their resources in ways some other sectors aren’t able to do adds value. They mobilise really quickly, they listen and respond, they find ways around challenges we’ve faced. They keep going with energy and commitment, and their commitment to making life better for older people. The leadership they show is a real credit to them.”
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04  A little more detail on how the magic ingredients bring about change
The guided conversation and continuity of support

How does it work?

- Trusting relationships are built over several home visits, enabling the older person to express their desires and needs freely.
- Goes beyond asking ‘What do you need?’, by seeking to discover what the older person can do for themselves, with a little help.
- Makes it possible for PICs to understand and work with clients to address the barriers they face to making change.

What change does it create?

- Older people are treated as equal partners in a discussion that empowers them to identify their preferences and goals.
- Care planning goes beyond a set of actions for health and care professionals to take. Instead, it focuses on how services and support can help ensure that older people’s preferences are met and their goals are achieved.
Multi-disciplinary working

How does it work?

- Provides an effective mechanism to:
  - establish and maintain trusting relationships and understanding of ways of working between various disciplines
  - improve understanding of the value the programme offers
- Facilitate timely access to coordinated care
- Shift the discussion and solutions away from a medical model

What change does it create?

- Establishes a shared understanding of the contribution that different practitioners can make to improving the care and the health and wellbeing of older people
- Older people receive co-ordinated care and support that responds to their holistic needs and preferences
Personal Independence Coordinators’ knowledge and support that extends beyond sign-posting

How does it work?

- Tacit knowledge which extends beyond ‘what’s on paper or a directory’
- Follow-through support helps to address the barriers to accessing care and support:
  - for GPs and healthcare professionals: follow-up support to chase other statutory services
  - for clients: support consists of ‘doing’ and enabling connections in a way that signposting alone does not achieve

What change does it create?

- Creates a single and trusted point of contact to access diverse care and support
- Older people are motivated and supported to take action to achieve their goals
- Makes visible the community offer
- People and services are connected in the community
“It would be a regressive step if [the PICP] wasn’t available. We’ve seen some progress: we feel there is an improvement in the care of our patients, we feel that we know them better for it. And I think our patients feel special because they know there is a service there for them, and they know we are trying to help, even with the non-medical issues.”

Clinician

“They have helped us to understand something more about our patients’ needs and wants, and demedicalised some of the issues people have. It has helped us get to grips with what the non-medical issues are, rather than just trying to solve everything through a medical model.”

Clinician