

Integrated Health & Social Care – designing around the citizen

| Overview

Taking care of people, their health and welfare needs, their social issues, and their relationships. This has to be one of the most complex systems that anyone can work in. Especially as this has to include the community and family circumstances, as well as the individual.

In England we have made it particularly complex, by the way government has seen fit to design the overall health and social care system. By fragmenting the various 'services' and private provision, this has unleashed forces that guide the behaviour of a myriad of organisations with different competencies and rules.

A systems approach is particularly apt to make sense of this complexity. It strips out the artificial barriers that are put in the way of doing the right thing, and allows a design of an effective system to emerge.

Many authorities are now experimenting with integrated working. The government and the NHS have recognised that the way forward is more integrated care. Integrated working ICS developing by each trust are now focusing on transformation and localisation of care.

Personalisation, patient centered, community, integration, community assets, key worker... They are all pushing against the monolithic approach of treating everyone the same. Now that this approach has proven itself, let's get going with what we have learned works.

Increasing demand into the health system, and signs of increasing waste in processes has been a factor in public healthcare for a number of years now. In particular, there has been a recent awareness amongst managers that the service that was being delivered was not a good service.

A team of front line health professions were brought together, for a period of over a year, to learn what the outcome would be if they were allowed to develop a person-centred approach, that was not constrained by the current systems. The team were made up of nurses, Occupational Therapist, Physiotherapist, Social workers, contact centre staff, an area manager, and a HLS facilitator.

The wider leadership team were connected to this from the beginning, with direct access to the team on a regular basis. Leadership development was included as part of this work.

| The HLS Approach

| Human

The main focus of the human aspect covered two main areas. The first was the staff in the team. How they worked together, and also their personal journey of developing a new working culture and relationships with each other. Of significance was psychological safety, the ability to bring their whole selves to work, individual strengths, and trust. The health service is delivered by people, not by technology or other mechanisms. This aspect of staff goes far deeper than simply talking about roles, but more the direction of how people work to their fullest. Dan Pink expresses that a human role should incorporate autonomy in the role, mastery of skills, and purpose with regard to achievement of purpose.

The other side of Human, was the design of a new approach that treated the citizens who needed help as whole people, and not as 'service users.' Service users and the focus of citizens in need in the past decades has moved towards people as customers. This means that citizens have to be understood as a totality, often including their relationships with friends and family. This is very different from health based episodic provision.

| Learning

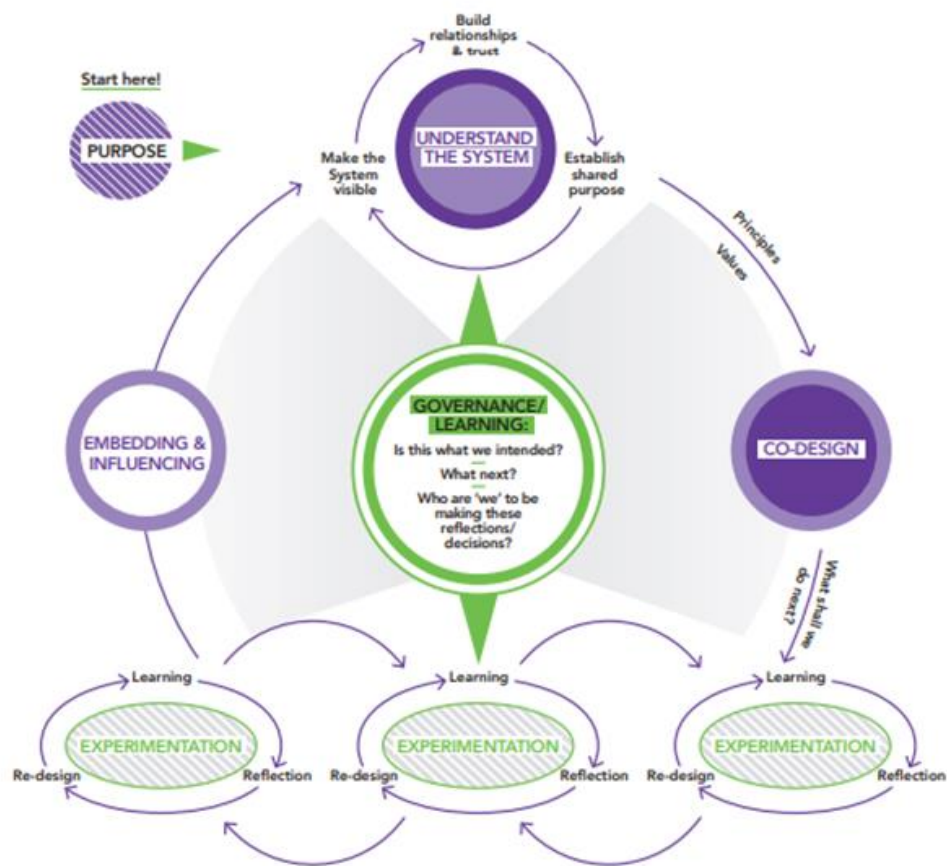
The whole purpose of the prototype was to learn what worked and what does not work. It is designed to inform senior leaders, who can then make further informed decisions as to how they would like to take that learning forward. Those leaders themselves need to go through a learning process over the life of the prototype. The team became adept at summarising the learning experience to a set of activities that occurs in a workshop situation, that takes leaders through journeys of learning. Under no circumstances would any outcomes be written up in the form of reports. And no reports were ever created for this work. Reports simply emphasise the current paradigm, as readers simply use the text to compare their current thinking with what they are reading. In addition, reports fail to convey complex narratives.

The primary mechanism to this progression of the prototype is learning – and learning that is directly experiential. This is required because the current paradigm of how our health services work, is framed in the principles of New Public Management. This design has been in place for so long, that it is very difficult to conceive of new ways of working within that frame. Therefore it is necessary to help leaders to enquire deeply into their mind-sets, to help them to understand a quite different paradigm.

| Systems

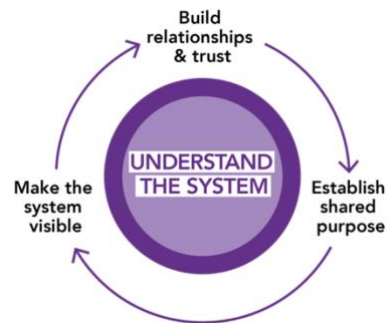
The healthcare system is perhaps the complex that is possible to understand. It is both national and encased in legislation. The links that citizens often require cover a myriad of various specialisms and healthcare practice.

The systemic nature of this prototype is in contrast to the mechanistic and reductionist design that currently dominates the health services. This systemic perspective is the frame that the team must embrace, to then focus on the person in need in new ways.



| Story of Change

| Understand the Service as it is

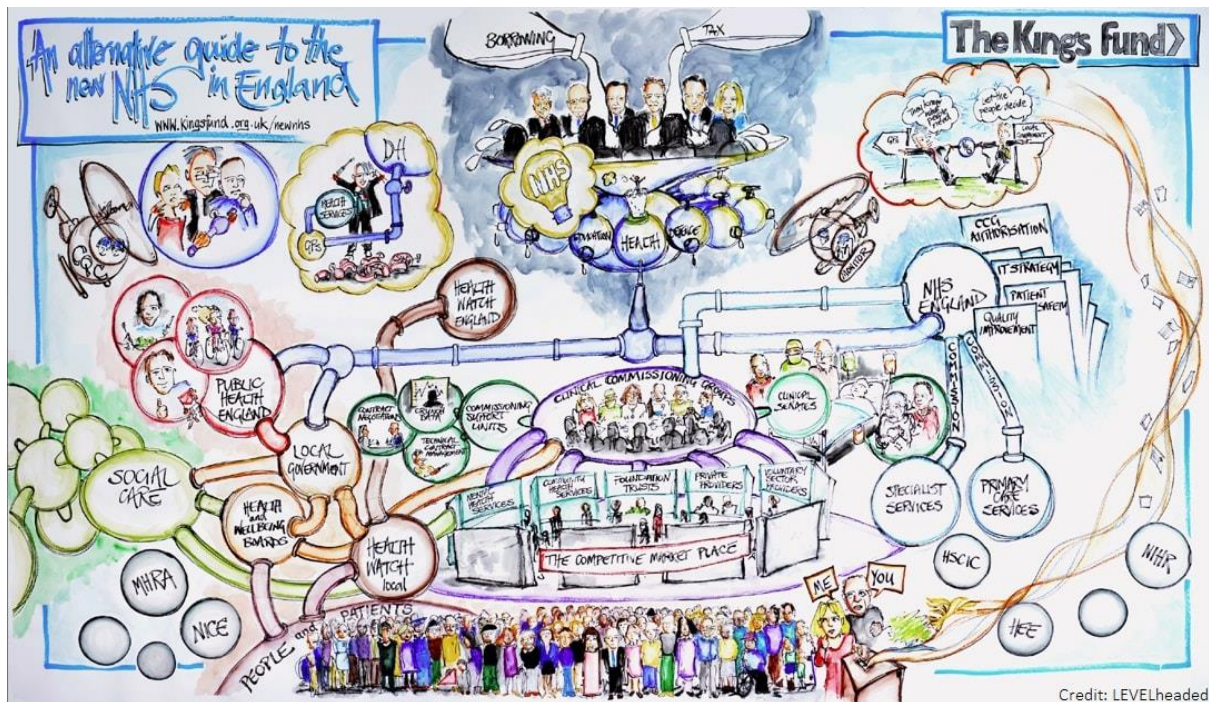


What we found

The team found that the current system was very inefficient and ineffective. This was characterised by high levels of waste in the operations. But more importantly, the citizen was being taken through a series of rule driven complicated steps, that that did not contribute to dealing effectively with the persons problems.

Doing the right thing	66% of demands, as they were recorded on the referral system, did not match what the person actually needed. People returned to the service in 71% of cases because we do not accomplish what is necessary.
Their need	In over half of the total demands, the person had no idea they had been referred to the service.
Understanding	We realised that the neither the staff nor the IT system, had an understanding of what the real needs of the person were. Formal assessments were widening that gap in understanding.
Management	The managers had no idea how the service was truly working, and changing the service that made it worse, not better. Half of all work that the staff undertake in the old system is of questionable value, and may not be necessary.
Costs	By focusing on cutting cost, the causes of cost increased the total cost.
Staff roles	The staff hardly ever used their full competence, they became automated to simply undertake daily activities.
The system design	The design of the system was highly functional, designed to deal with standard clinical activities. Individual referrals were created from a rule based 'sausage machine.'
The demand, the need	All demands and needs were complex, requiring a team-based approach to looking at the problems to remedy.
The information	The information recorded almost never reflected the true nature of what mattered to the person. And much of what was written was of no value to anyone.

The system itself was so complicated, that there was no realistic way that the staff in the system could function well, despite individual or team efforts.

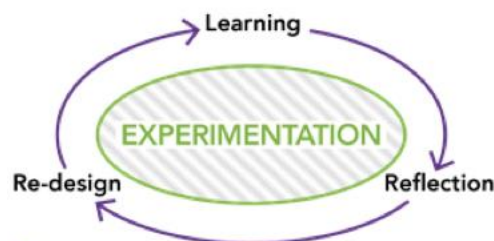


The reality of the NHS, viewed as a machine

The managers realised that they were partially responsible for this current situation as they had put in a series of assessments and rules that were designed to help staff to follow a standard process, to reduce risk, and to minimise cost. Those in the work were bombarded with increasing levels of demands on their time, creating a highly stressful and activity focused mindset, resulting in low morale and a personal distancing from what really mattered to patients.

It was realised that citizens core issues were often not resolved until too late if at all, resulting in months or years of unnecessary treatments. Citizens would bounce around the public health system with little progress of improvement to their overall lives.

|The Experiments.



The team took 35 demands from end to end, and focused on the needs of the citizen by applying a set of new operating principles to each person. This allowed the team to learn how to approach and deal with people in a way that focused on getting them back to a stable and healthy state, and not simply reacting to what was written on the referral sheet! The barriers to making this happen had to be temporarily suspended by the leadership, including any time or other restrictions that would normally be in place.

The staff were so conditioned by rules, that the team were surprised at how difficult it was to

learn how to actually listen and understand someone's life context free of pre-determined structures. It took a good week of working together, to wean themselves off using assessments.

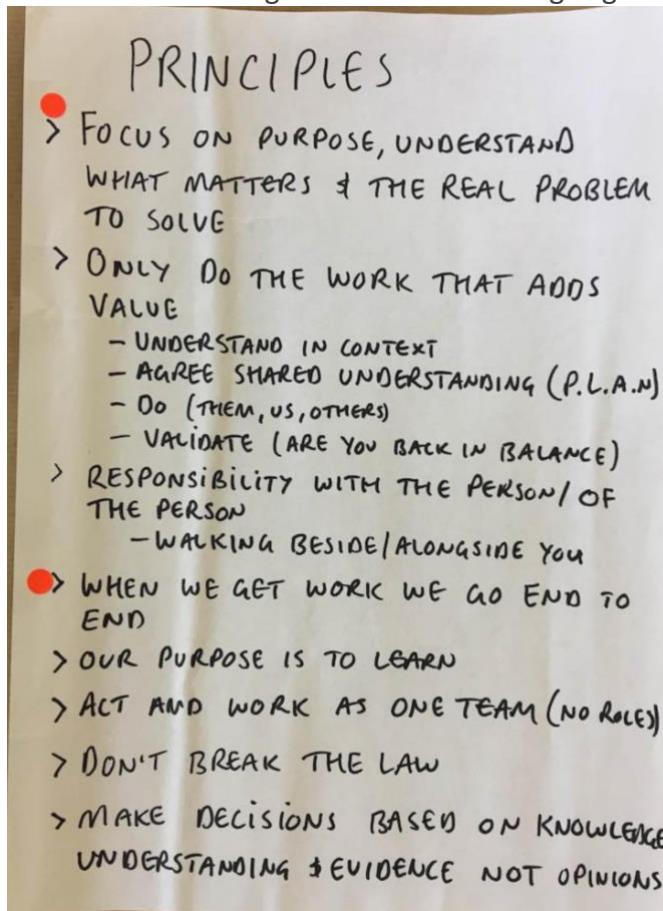


Figure 2 Experimentation principles



Figure 12 A case in detail

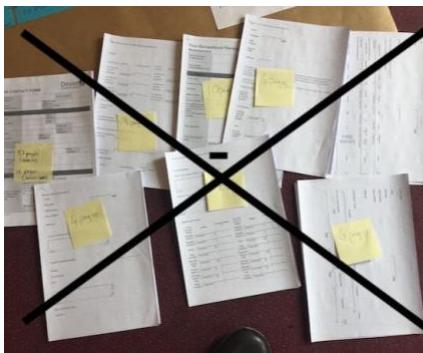


Figure 3 Summary of all the cases

Step 1 Understand me & what matters to me

Each team member took demands, and the first step was always to understand the nature of why the person had come to them in the first place. In most cases this required a visit. That activity continued until they developed a level of trust and got to learn clearly the circumstances about that person.

“Understand each person in their environment and those around them.”



Discard assessments and actively
listen



What is their environment like?
Who visits? Any relatives? Are they
happy? What are they not saying?



Step 2 Decide the best agreed course of action

This is about assessing the whole situation of the person, their environment, and their friends and family. In the majority of cases what was required had little to do with clinical help. There were few restrictions placed on the team, and they were able to pull on any of the clinical or other expertise from anyone in their team if needed.

Step 3 Keep ownership, and maintain the person to get back into balance

We are engaging with the citizens and we are directly available at the end of the phone if required. Whatever the team think needs recording is written down. This is where we don't simply close the case when the original request is completed, we ensure that they have got to a place of stability.

Step 4 Close

We close the case when we have agreed with them that we have provided enough support. If they contact us again, the same team member is assigned the case again.

| The New Design

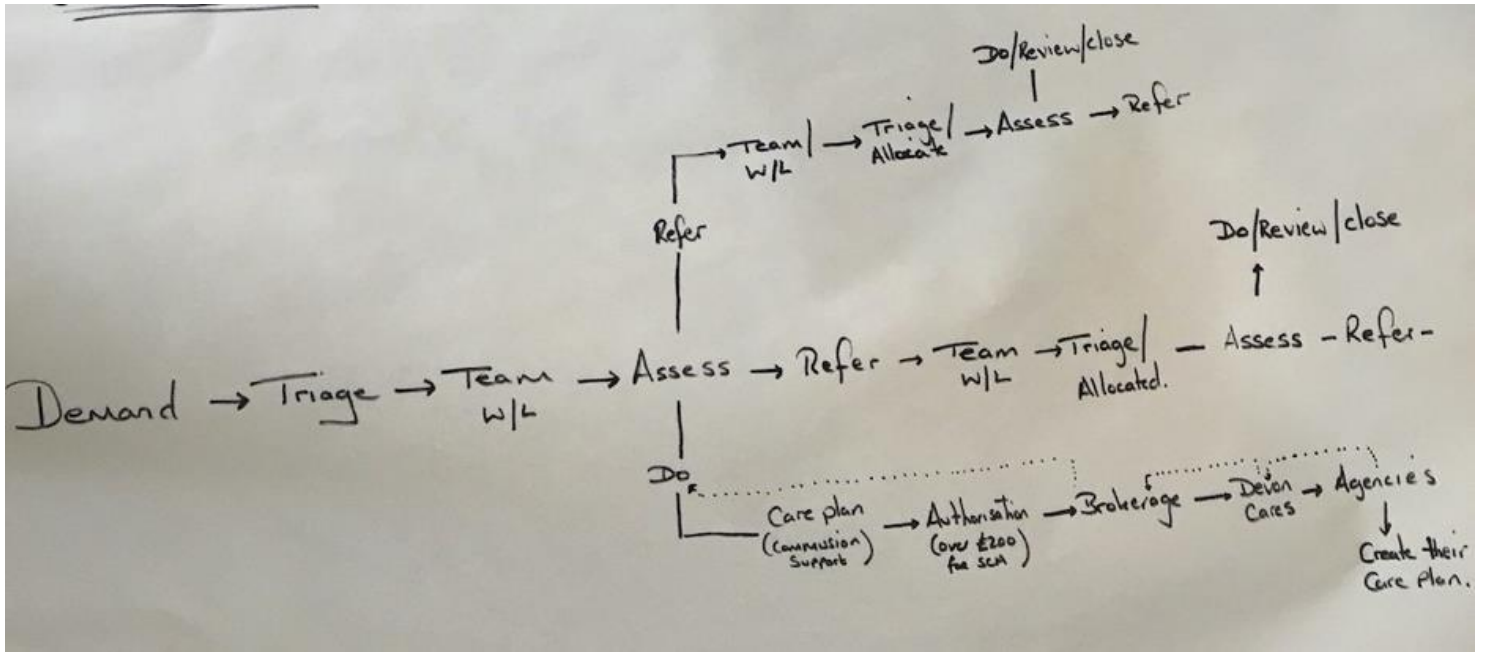


Figure 4 The current health workflow

The current system - transactional and functional, and has no single point of ownership

The new system - is based on a network of communication and single point of ownership

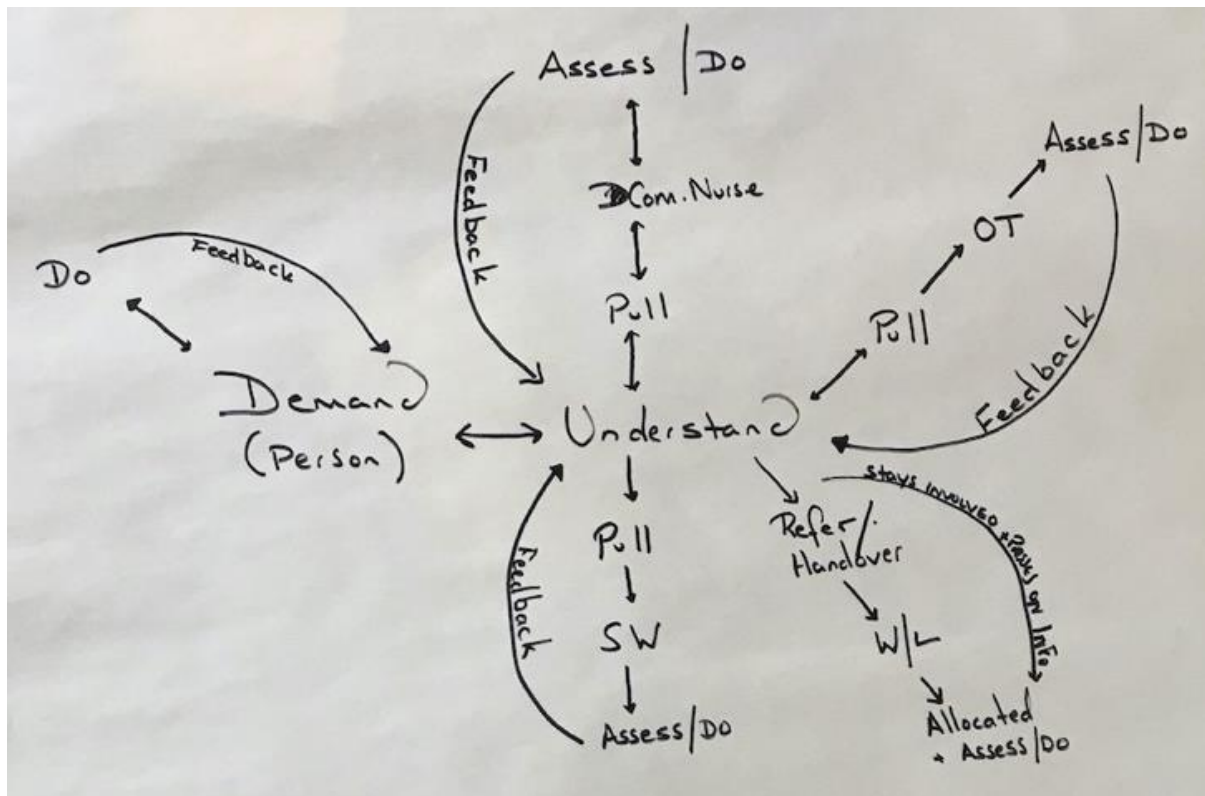


Figure 5 new network based health workflow

Purpose & the Relationship with Citizens

The actual purpose of the service that the managers focus on, then drives that which the staff focus on. Subsequently, the measures follow that purpose to ensure that the purpose is achieved.

The real purpose of a service is often never discussed or understood openly. But we did.

Old purpose

To work on the task in-front of me, as quickly as possible, following all the rules.

It drives me to lose sight of actually helping someone, and I feel relieved when I can refer it on to someone else.



New Person centred purpose

Understand what matters and help the person to achieve balance in their lives.

It drives me to focus on what matters, and to only do those things that I need to

And if the services are redesigned around this new purpose, what do you think will happen?
What will happen to costs?

As we were examining the service from a citizen perspective, the relationship we have with them changed...

Relationship with citizens moves from; *engage with us*, to *engage with you*.

Power moves from; *power over*, to *power with*.

These are two fundamental changes to the way that we perceive how our service interacts with citizens. We began to understand what putting the citizen in the centre of the design really was about.

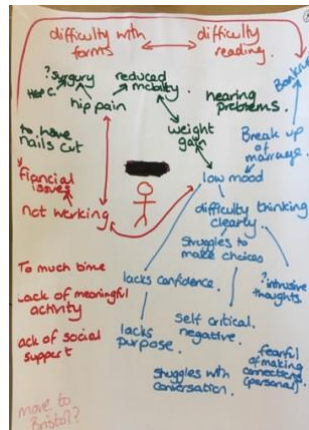
DAY + NIGHT DATA

CASE NO	2		3A		3B		4	
	PROTOTYPE	SYSTEM	PROTOTYPE	SYSTEM	PROTOTYPE	SYSTEM	PROTOTYPE	SYSTEM
START DATE	30/4/19	30/4/19	2/5/19	26/4/19	2/5/19	26/4/19		
LAST UPDATED	5/6/19	5/6/19	7/6/19	7/6/19	7/6/19		5/6/19	
PEOPLE	4	7	7	13	4	5	7	18
NO OF ASSESSMENTS	2	15	7	15	3	4	6	9
NO OF REFERRALS	0	4	2	5	1	1	4	7
TIME SPENT	3 HRS 20 MINS	30 HRS 30 MINS	7 HRS	17 HRS	4 HRS 10 MINS	5 HRS	5 HRS	8 HRS 30 MINS
% CONTACT TIME F2F / TEL	F2F 30% TEL 45%	F2F 75% TEL 0%	F2F 71% TEL 5%	F2F 60% TEL 2%	F2F 90% TEL 3%	F2F 0% TEL 45%	F2F 90% TEL 5%	
OUTCOMES	LISTENED TO	EXERCISES - BALANCE CLASS - SPECIALIST DOCTOR	W/CHAIR DFG SOCIAL ACTIVITY? ONWARDS CHECK-INS	W/CHAIR DFG ONWARDS REFERRALS EXERCISES	FEEL UNDERSTOOD SOCIAL ACTIVITY WITH PARTNER	NOT ATTEND DAY CENTRE	CAREER SUPPORT BENEFITING ACTIVITIES TO ATTEND	
BACK IN BALANCE Y/N + DATE	Y 30/5/19	N/A		N/A		N/A		
PROBABILITY OF RETURN (L/M/H)	L	H	L	M	L	H		

Figure 6 Detail of the measures the team captured

A case study, as presented to the senior leaders

The power of story-telling, to describe a complex situation. If you want to experience what this is actually like to be taken through a case study by the team, and you have about 16 minutes, you can experience it below, Eleisha talking about Len. Senior managers were the audience.



[Click here to go to Lens Story video](#)

| What have we achieved?

As an example, this is what we found about one of the people we work with, Anne

My problem – *I have complications with my wrists, and everything I touch feels hot. It is a condition that is not curable.*

What matters to me - *I need help to live as normal life as much as possible. I need help dressing, cleaning the house and cooking.*

What we found about our current way of doing things	When we helped Anne in a joined up way
Value work 4 hour 20 min	Value work 5 hours
Waste work 10 hour	Waste work 1 hour
People involved 19	People involved 5
Handoffs 17	Handoffs 0
Documents 33, 132 pages	Documents 3
IT systems used 6	IT systems used 6
End to end time 100 days	End to end time 10 days
Outcome; No real improvement in my life	Outcome; I manage my problems myself now

The solution was not about fixing her chronic condition, it was actually about helping her to continue to live her life as normal as possible. What we provided was adaptations and advice.

We also found a teenager who lived nearby that needed help with her reading and writing, which Anne was very happy to help with, in exchange for the teen helping around the house with cleaning.

Before we took this case on Anne had been bouncing around the service with five referrals that had no meaningful impact over two years.

This was a typical case that would bounce round the community health office, and over time the service user would either make repeated demands, or lose interest and stop connecting with the health service. A typical failed outcome that shows how we can spend lots of time going round in circles.

It's tempting to view this experiment work as simply introducing a 'single point of contact', or a 'multi-disciplinary hub', or 'sharing data'.

The reality is that the real change is in the thinking and approaches of those in the new system, in Anne's case above, one person actually did most of the value work with a new decision framework and the ability to make local decisions.

It took senior managers to give the team permission to avoid what we needed to:

- ignore departmental cost centres
- don't refer on, keep ownership and get advice from others if needed
- aim give the service user whatever help they need when it is not a clinical solution.
- only use the paperwork that needs to be completed, and only do it once

| Enablers, Barriers and Tensions

The reality was that the main barriers has been removed by the leadership. Allowing a team to be distinct from the current system, in one large room, was the primary strategy to dissolve barriers.

The key aspects of the barriers were actually within the minds of the team themselves. It was the continued work they did together that dissolved these over time.

Perhaps some of the key enablers were:

- Access to a systemic convenor, who could guide the prototype through the HLS approach.
- The inclusion of a manager in the team.
- Facilitation that focused on helping the leaders to learn and reflect.
- Leaders willing to remove barriers when asked to.
- The time needed to make this happen, using a full time team.
- Using the team to develop their own measures, and allow them to engage directly with leaders using narrative and story-telling.

| What have we achieved?

Outcomes of the Prototype

The summary of all the cases taken in the experiment, compared to the traditional approach

The number of assessments,	down 64%
No of people involved end to end,	down 32%
No of referrals,	down 41%
Total number of hours spent on the cases,	down 14%
Face to face time as a percentage of total time,	from 46% to 60%
Estimate of that demand returning into the system,	from 71% to 0%

All the demands taken were complex, highlighting the fact that a flexible and non-standard design of the work should be the norm.

By getting good understanding, and work with the cases end to end, we reduced repeat demands into the service from 71% to almost 0%.

Leadership and management

- Role of the manager is based on trust & knowledge to delegate certain decisions.
- The reality that the manager does not have or should have all the answers. Learning & uncertainty should be recognised as good leadership traits.
- The manager must be able to distinguish between staff working hard vs staff working on the right thing.
- My job as leader is to help make a team work effectively through understanding what makes a good team work well, and to ensure staff have a good job to do.
- Understand that culture & motivation is an outcome of my leadership.
- Understanding that the system is a result of my design and my thinking.
- A standard approach to making decisions and processes hinders the work and creates waste.
- Learning happens within the work itself.
- I recognise that truly Understanding a person is essential to this service, and I have to ensure it happens when we are busy.

The effect on the team

- The team developed a new way of working together, that allowed them to be open and honest with each other.
- We work on our relationships with each other and I bring my whole self to work.
- We support each other with no conditions.
- I now see my whole work here completely differently, I don't want to go back to my old work.
- I am now using all my abilities, it fulfils me.
- I am motivated as I connect directly with the outcomes we are achieving.
- My manager supports me.
- I enjoy coming to work.

| The Learning

In this health system, services like this develop such waste and poor outcomes due to the functional nature and standardisation of the flow of work. The learning from a managers perspective, was that if they truly looked at their service end to end, and that by understanding that the real demand and what matters to people should drive the work that we need to do. So, unless the systemic problems were redesigned, no amount of changing of rules, procedures, or IT system results in real sustained improvement

Delivering care across existing systems will be a key development for the future of service delivery and evidence suggests that a “**systems thinking approach**” will be required to understand the environment and the complex interactions within it.
Commissioning for Effective Service Transformation, NHS England