

# From collaboration to collaborative – developing robust care systems through trusted relationships

An exploration of how various stakeholders worked together to improve performance, strengthen relationships and help transform the Torbay health and care system.

## Introduction

In January 2021 during the midst of the COVID-19 pandemic, Torbay health and care system long noted for its good performance for supporting discharges into community settings achieved zero outstanding packages of domiciliary care. In 2017, the number of outstanding packages was rising with a level of 287 hours of care being required, needing to be placed; working with the in-situ providers in the ensuing three years the number of outstanding cases was reduced by 92 per cent and with outstanding hours required being reduced by 89 per cent.

But this only tells part of the story, as during this period the number of clients and packages of care rose.

| Number  | January 2018 | January 2021 | Percentage change |
|---------|--------------|--------------|-------------------|
| Clients | 626          | 776          | +24%              |
| Visits  | 6,362        | 9,817        | +54%              |

In this paper we explore the components to this achievement, and how the various stakeholders worked together to improve performance, strengthen relationships and transform at least part of the system to get us to where we are now. We hope to provide encouragement and hope to others facing similar challenges, not only in the field of home care, but in all systems involving a multiplicity of players, each needing to play their part for the delivery of a service to be successful. Success in many areas of the system will include capacity, the ability to deliver care to the people who need it and the time they require it in a more integrated way; that takes a collaborative effort.

The white paper 'Integration and innovation: working together to improve health and social care for all' (Department of Health and Social Care, 2021) states:

*We have seen collaboration across health and social care at a pace and scale unimaginable even a little over a year ago. The NHS and social care providers have delivered outstanding care to those in need while at the same time radically changing ways of working, reducing bureaucracy and becoming more integrated. New teams have been built, adoption of new technology has been accelerated, new working-cultures developed, and new approaches to solving difficult problems pursued.*

The publication also makes it clear that integrated and collaborative approaches are a policy commitment. It mentions:

*The experience of the pandemic has made the case for integrated care even stronger and has redoubled the government's determination to ensure that public health, social care and healthcare work more closely together in the future than ever before.*

Torbay's development of its Care Collaborative over the two years pre-pandemic provided enhanced foundations for meeting the challenge and ongoing developments towards the aims of the white paper. The pursuit of high quality, outcomes based care was articulated in a clear set of principles for the Living Well@Home programme; the ageing population in Torbay, (27% being over 65 compare to just 18 per cent in England and this rising to 34 per cent by 2040), the need for high quality care, integrated service delivery and enhanced working was evident. The pandemic affirmed the need that was already present.

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## **Situation**

In many ways the situation in Torbay reflected other parts of the country. Years of austerity had increased pressure within the care system, heightened tensions between commissioners and providers and reduced the available resources. At the same time ideas for new ways of working were beginning to emerge, for example exploring self-organised teams based on Buurtzorg's model of care and person-centred approaches.

Torbay had been exploring different market models for ten years, developing local providers, working with social enterprise models and prime contractor arrangements. Since the formation of the NHS Care Trust delivering integrated health and adult social care services in 2005, engagement and co-production has long been at the heart of the way of working (Thistlethwaite, 2011). With the integration with the [acute] NHS Foundation Trust in 2015, the breadth of services within the organisation offered significant opportunity for development but at the same time required increased levels of understanding across partners as to the different roles each played in the enhanced arrangement.

Torbay had solid and, compared to many, enviable foundations in its market relationships. By late 2017, however, the system was faced with the challenge of waiting lists for packages of home care and the consequential impact on delayed discharges from hospital. It was clear that tensions were rising across the system and communication was becoming more fractious than it was facilitative. There was a collective endeavour in front of us to make the right thing to do, the easy thing to do; there was responsibility on all parties.

## **Response**

In response to this situation, we decided to increase our efforts for transformation by bringing together the various parties involved. A key part of collaborating is knowing when to ask for help; at this point that ICA:UK were invited to join the initiative, bringing their experience of participatory processes and facilitation to convene people, to deepen the relationships between the various parties and to identify a common way forward. In December 2017, a meeting was called to bring together system partners, health and care, private and public sector, operations and commissioners that were involved with or impacted by the provision of domiciliary care in Torbay. The purpose of the meeting was to explore how the various players could best collaborate in order to respond to the expected pressure on the service that occurs during the winter months. Although the room was decorated for Christmas, the atmosphere was hardly festive.

Apart from the seriousness of the issue, there was a feeling of reluctance, even resistance, which people brought with them, based on years of not being listened to; memories of previously failed efforts to work together more effectively,

and a sense that nothing would change. People from all parts of the system held back, often staying in small groups of those they knew, not mixing; the perceptions and feeling held through existing relationships being reinforced.

Nevertheless, progress was made. The ability for participants to have a voice and with this way of working, for those views to be made tangible (a record for reflection, review and action) was a key success factor. One might consider it 'managed venting'.

Through the evident energy in the room we managed to identify and agree together a number of areas in need of attention, some short-term (in the face of the annual winter pressures) and others more medium term. Reaching such an agreed set of priorities was helpful, but without discernible action, there was still the danger of them joining the long list of previously agreed priorities which, for different reasons, had not become reality.

We responded to this challenge in part by addressing the aspects of transparency and accountability. Meetings were scheduled quarterly, and over the next two years, emphasis was put on involving people in the agenda-setting, in ensuring that people had the opportunity to speak and be heard, but also in encouraging openness and greater accountability both at the level of organisation and named individual.

The response, however, was not just about increasing the number of meetings — it was important to make progress and to demonstrate and share that progress with everyone involved. A "you said, we did" session takes place in every meeting, setting out the actions agreed at the last meeting and the extent they have been implemented in the months since. Significantly, that has evolved more into "we said, was done" scenario, recognising that success depends on "we" not "us and them."

From the initial meeting, the group agreed the key areas for attention in December 2017 were:

- To streamline the brokerage process (allocation of packages of care to the providers)
- To manage expectations
- To match capacity with demand
- Better care of staff
- Financing
- To work better together as a team
- To meet specialist needs

Specific actions were prioritised within those for short-term attention, but those areas have remained the key focus behind the changes subsequently introduced.

In our work we distinguished between changes that were more transactional (i.e. designed to increase capacity within the existing system, more concerned with effectiveness and efficiency) and those we saw as transformational (i.e. aimed at achieving better outcomes for all by developing a new system, changing relationships between stakeholders). The distinction between the two categories is not always clear cut. We learnt, for example, that transactional changes can have transformational outcomes, and how a transaction can become transformational by the way in which it is introduced and implemented.

During 2019-20, for example, the decision to move from a primary provider model (contracting with one provider to bring in and oversee others) to a framework agreement with multiple providers working as a together could be seen as transactional. The way the decision was taken, however, and the subsequent process through which the agreement was developed and refined with the providers selected was transformative in itself. Never before had the providers been involved in formulating the agreement, setting the Performance Indicators, nor had the Procurement team embarked on such an inclusive and participatory approach to finalise the new contract. In turn, providers felt heard and listened to, more respected and deeper ownership of the contract which they had helped shape.

At the same time the specification size was reduced by a third (57 pages to 38), was tighter and more meaningful with all agreeing that the outcomes were clearer and better for clients and staff, driving person centred care; result: no surprises in the contract, collective commitment to delivering it and making it work.

We also recognised that, while our ultimate goal is transformational, small improvements within the existing system can play their part too, contributing towards the sense of progress, maintaining momentum and helping to raise morale. Even small developments like obtaining NHS lanyards for care workers and enabling them to access discount schemes with vouchers for goods and services can make a difference. More substantive actions included response to the issue raised in respect of Christmas with short term increased funding, demonstrating a commitment, carrying a message of progress, and improving morale and motivation.

Other actions were designed to be more transformational from the outset. The setting up of the Care Collaborative itself, for example, provided a regular forum for all stakeholders and allies to come together to share successes and tackle collective challenges. The transformation programme also established its own representative governance structures with providers as clear partners being members of the working groups (task forces) and decision making boards, establishing and applying criteria for projects, allocating funding and liaison with the senior leadership of the Council and local NHS.

It was through this Board structure that the attitude to risk changed — seeing projects as “experiments” — there to explore new approaches and ideas. If they work, to go on to share and expand; if they don’t, to learn from or refine. It was a step in developing a culture of “no failure where there is learning.”

In 2018, three task forces were set up to carry forward the themes of Recruitment and Retention of Staff, Self-Managing Teams, and the development of an E-Platform to enhance communications and knowledge management. In addition to the experiments, they also carried out research and worked to bring in new developments. At the same time, individual providers were also trying out new approaches and ideas, both for their own development but also to share with others and for them to adopt or adapt as appropriate.

## Impact

By December 2019, when the Collaborative met bringing a wider group together but still including many of the same players who had been present two years previously, the difference was apparent. Instead of the division and tension that had characterised the meeting two years earlier, the atmosphere was business-like, and upbeat. Many of those present knew and greeted each other, and newcomers were welcomed, ‘supported into the fold’. Instead of a sense of reluctance and resistance, trust and openness characterised the exchanges. Instead of competitiveness, there was a sense of collaboration, of being part of something bigger which had already led to improvements being implemented and which held the promise of more to come.

In March 2020, the arrival of COVID-19 brought new challenges to the sector, testing the strength of the relationships more severely than ever before. The response showed the extent of the transformation that has taken place:

- Open calls for and between all the providers, the NHS Trust and Council took place two to three times per week to share information, offer and ask for help, agree common actions. For example, this communication led to the solving of problems connected to the acquisition and distribution of PPE, to help with clients when carers were off sick.
- Structurally, despite the demands of COVID-19, through collaborative working on 1st April 2020 a new five year framework domiciliary care contract was put in place as planned, capacity was maintained and there was not a single complaint from a service user. By the 5th May 2020 outstanding packages of domiciliary care in Torbay were reduced to single figures.

In July and August 2020 a series of reflective conversations was facilitated across the membership of the collaborative. The report concluded, “the Care Collaborative has developed into a platform which has improved communication, developed mutual understanding, deepened relationships, and built greater trust between all the parties involved. In turn this has led to improved effectiveness and efficiency as parties have been able to work together as partners, often sharing resources to overcome challenges and address issues.”

In January 2021, the level of care hours required had increased by 54 per cent and capacity was developed to achieve no outstanding packages of care – zero, with the supportive, collaborative interactions being business as usual stemming from generative relationships.

At a person centred, client/patient level it is evident that this was the right thing to do. As a framework to support the dissemination, one model often used is the four drivers for change – Politics, Policy, Money and Measurement.

|             |                                                                                                                                                                                                                                            |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Politics    | Locally and nationally the NHS and Social Care services wish to be seen as high performing – delayed discharges of care and bed capacity is a key issue                                                                                    |
| Policy      | Care closer to home, ensuring people with increasingly complex needs remain in their own home. People are not delayed in leaving hospital when assessed as medically fit to do so [Hospital Discharge Service: Policy and Operation Model] |
| Money       | Costly to have people in the wrong setting, cost of non-value-added activity (inefficiency), value of care workers                                                                                                                         |
| Measurement | Increasing number of outstanding packages of care, delays to hospital discharge, retention and recruitment challenge                                                                                                                       |

## Key learning points

Embrace the passion – We talk of compassion in health and care. A key element of that is (com)passion. The flip side of positive passion is rage. People can only rage when they care about something; no one is ever outraged when indifferent to an issue. The challenge is how to harness that positive and negative passion for creative outputs and good outcomes.

This work has affirmed once more that strong relationships, supported by appropriate structures and systems need to be at the heart of transformation. The emphasis on openness, transparency and accountability; demonstrating an ability to listen and allowing voices to be heard; leading by example, all led to a significant shift in levels of trust both within and between the various parties involved. Trust is a fundamental part of Transformational change and until Transactional processes are understood and the challenges shared there is not the foundation on which to develop broader aims. In reviewing the Five Laws for integrating medical and social services (WN., 1999), Shortell (SM., 2021) recognises the importance of “each organisation getting to know one another well enough to determine their comparative competencies and to develop trust and confidence in each other’s capabilities.”

A further affirmation is that having well-managed processes that allows the energy – the passion – to surface, be shared, explored and constructively deployed to good outputs is a key component. Working with the right partners within and external to the system, asking for help and being guided supports better outcomes, in this narrative getting people the care that they need when they need it.

Using tools and techniques to foster engagement and create the environment for good things to happen.

Staying the course is vital – it’s not a quick fix but results can be achieved early on and built. It takes commitment to the planning and set up, what can look easy is nuanced and working with behavioural dynamics takes skill. The reward is both good outcomes and a legacy of learning and skills within the local system. Senior level engagement and a

commitment to continue to give this due attention, “drive” it, is important; the level of resilience required with the pressures of a system is not to be under-estimated, including the challenge of prioritising what may be seen as a nice to have or the dangerous element of ‘we can do this next month when things are quieter’.

In the early stages, it was not just a division between providers and commissioners/operational managers but between providers themselves. They saw each other as competitors and unwilling to share too much for fear of losing their share of the market. After twelve months of working together, however, the image of competition faded, to be replaced by recognition of the fact that there is more than enough work for everyone, and that collaboration is the way forward. Further, collaboration and partnership should not be seen as “nice to have”. It needs to be at the heart of a successful approach.

Shared values and mutual respect – one of the most moving and memorable observations voiced at our third meeting was when a quiet, rarely vocal provider asked to speak, stood up bravely and said, “what we should realise is that this is a non-competitive environment.” She referred to the scale of the capacity challenge and development of care in community settings. The future for care closer to home was wonderfully bright but would need a collaborative approach. All those present concurred; it was a key point in the relationships and one that brought us all to remember this is about Person Centred Care.

Actions speak louder than words – Let’s not say this is a priority, let’s show that we’ve done something about it. A further insight is the need for commitment but recognising that for people to stay engaged and active in their efforts to bring about change, there needs to be signs of others’ commitment, signs of progress due to collective effort and a level of consistency across decisions being made that illustrate that there is leadership buy-in (or at least tolerance). Developing a level of consensus around the areas in need of attention in December 2017 helped bring the different players together and helped them unify around these common goals. Such agreement was not, on its own, enough. The commitment needed building and maintaining through ongoing communications, meetings and by example. No quick fixes were offered, and expectations were managed.

## **Next steps**

Significant progress has been made over the past three years. There are higher levels of trust and confidence and a growing sense of connection and community. These are, in turn supported and maintained by the overall guidance of the framework agreement, and maintained by the increase in communications as well as the changing ways of working. Virtual working and the growing use of and comfort with virtual meetings have made their own contribution to this transformation. There is also an interest in and willingness to engage with more stakeholders who are involved in home care, either directly or indirectly e.g. voluntary and community organisations. Already there are examples of individual providers trying out new approaches and sharing their findings with others.

It is also clear that further transformative work is there to be done. This isn’t a one-off deal even over an extended period. It’s a cultural shift. It takes time and requires ongoing attention, nurturing and resource but it becomes “the way we do things around here”; transformation and evolution being part of a continuum, an iterative and shared process.

We recognise more inward and outward-facing work needs to be done both to strengthen the Collaborative further and to identify and test new approaches which will help move the system to provide a better service to clients, better support for carers and be better able to cope with what are becoming greater and more chronic pressures.

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