



# THE JOURNEY TO INTEGRATED CARE SYSTEMS

SEPTEMBER 2018





Welcome to the third report in our *Provider voices* series in which we present the perspectives of NHS trust leaders, and leaders from the wider NHS, on some of the key issues facing the health service today.

Creating a truly integrated health and care system is a key strategic objective for the NHS. Our latest report is therefore devoted to exploring the challenges and opportunities presented by local sustainability and transformation partnerships and integrated care systems. We hope this will make a valuable contribution to discussions on what is working at a local level and where the challenges of integration lie.

As the report shows, the focus on collaborative working raises important questions for providers and the wider health and care sector on how to effectively build relationships and work together at a local level to deliver joined up, higher quality care for local communities.

From navigating the purchaser provider split in the context of system working, to working with multiple organisations across their footprint to develop a common vision for a shared population, the challenges and opportunities of cross-system working are significant. Eleven leaders from across the sector describe what is working, what lessons they have learnt and how their local sustainability and transformation partnerships and integrated care systems have evolved. It makes for interesting and timely reading.

I hope you find it useful.

As ever, we are grateful to all who took the time to contribute to the report and to Andy Cowper for carrying out the interviews.

**Chris Hopson**  
Chief Executive, NHS Providers

11



**SIR CHRIS HAM**  
Chief Executive  
THE KING'S FUND

16



**MICHAEL MACDONNELL**  
National Director,  
Transforming Health Systems  
NHS ENGLAND

18



**ALAN FOSTER MBE**  
Lead  
CUMBRIA AND  
NORTH EAST STP/ICS  
Accountable Officer  
NORTH TEES AND  
HARTLEPOOL NHS  
FOUNDATION TRUST

21



**DAVID PEARSON CBE**  
Deputy Chief Executive  
NOTTINGHAMSHIRE  
COUNTY COUNCIL  
Lead  
NOTTINGHAM AND  
NOTTINGHAMSHIRE ICS

26



**SAMANTHA JONES**  
Former Director,  
New Care Models Programme  
NHS ENGLAND

29



**SARAH DUGAN**  
Chief Executive  
WORCESTERSHIRE HEALTH  
AND CARE NHS TRUST  
Chief Executive Lead  
HEREFORDSHIRE AND  
WORCESTERSHIRE STP

34



**CHRISTINE OUTRAM**  
Chair  
THE CHRISTIE  
NHS FOUNDATION TRUST

37



**KARL MUNSLOW-ONG**  
Deputy Chief Executive  
CHELSEA AND  
WESTMINSTER HOSPITAL  
NHS FOUNDATION TRUST

41



**JAGTAR SINGH OBE**  
Chair  
COVENTRY  
AND WARWICKSHIRE  
PARTNERSHIP NHS TRUST

44



**TIM GOODSON**  
Chief Officer  
DORSET CCG  
Lead  
DORSET STP/ICS

48



**ANDY BURNHAM**  
Mayor  
GREATER MANCHESTER  
COMBINED AUTHORITY

The promise of a new ten-year plan for the NHS and the social care green paper, due in November, offers a natural moment to reflect on the value which collaboration in health and care systems can deliver for local populations. The pace of change in the NHS has been rapid since sustainability and transformation plans were introduced in 2015. In a few years, we have seen plans develop into partnerships and an aspiration that all STPs become integrated care systems (ICSs), taking collective responsibility for resource and performance management, and accelerating integrated care models.

STPs and ICSs vary in composition, population size and geography, and are all at different stages of development. However, this series of eleven interviews – including trust chairs and chief executives, leaders from commissioning and local government, national policy makers and thought leaders – provides a reassuring sense that common themes are emerging, both in terms of what drives success, and what enables improvement. In this overview, we summarise those common themes and look to what the future holds for collaborative working and integration.

## Putting local populations at the heart of system working

### A focus on outcomes, not structures

Given the different component organisations within an STP, it is apt that the local leaders we spoke to commonly described a shared focus on what all their system partners have in common – their populations, and in turn, the places in which they live.

Our contributors describe improvements in population health management and outcomes as the prime objective of collaborative working and integration. As Professor Sir Chris Ham, chief executive of The Kings Fund puts it: *“The biggest potential gains are better outcomes and patient experience but also important are fewer handoffs and delays. Integrated care won’t reduce how much we spend on the NHS but it should enable resources to be used more effectively.”*

This sentiment is echoed by Jagtar Singh, chair, Coventry and Warwickshire Partnership NHS Trust: *“A move to place-based care should be about improving outcomes for patients. There are also opportunities to improve the practical support that partners offer each other, for instance improving clinician-to-clinician communications or exploring how a community and mental health trust can support an A&E under pressure.”*

### Developing a sense of place

In Michael MacDonnell’s view: *“Integrated care is not about structures, the wiring behind the scenes or even money flows. That’s why, although systems*

*are important, the action is really in neighbourhoods and places. This is where the hard but exciting work is done to (re)connect clinical teams across traditional organisational and professional boundaries."*

Most of our contributors similarly recognise that a sense of place is a catalyst for change on much smaller, more manageable, footprints than an STP or ICS footprint. Professor Sir Chris Ham reflected on this trend within the ICSs in particular: *"Many of the most positive developments in ICSs are happening in neighbourhoods through the creation of integrated teams serving populations of between 30,000 and 50,000. Frimley is a good example and it has begun to bend the demand curve for hospital care by delivering more care in the community..."*


### A preventative and multi-disciplinary approach

Michael MacDonnell's vision for integrated care within systems is clear: *"Chronic conditions... require continuity of care and joined up services that help people manage their own health. Preventing or managing these conditions requires services to get upstream... This is what integrated care means: the NHS and local government collaborating to provide joined up services that are 'anticipatory', with the aim of preventing ill health or unnecessary hospitalisation."*

Both local and national system leaders emphasised primary care, social care and local authorities as key partners in this endeavour. Samantha Jones describes: *"Really interesting work [in Oldham] with... local authority leaders, taking accountability and responsibility for commissioning, with a strong focus on the wider determinants of health and working closely with a range of local providers including the voluntary sector."*

In a similar way, Andy Burnham, mayor of Greater Manchester Combined Authority, identifies the role NHS organisations can play in partnership with other system partners to address the wider determinants of health: *"Debt, poverty, housing, relationships and work are often the root causes of poor health in Greater Manchester... NHS organisations have a key role to play in supporting a more preventative, longer term approach to wellbeing and in paving the way for wider public service reform."*

David Pearson, integrated care system lead for Nottingham and Nottinghamshire, corporate director, adult social care and health and deputy chief executive, Nottinghamshire County Council, was one of a number of contributors to emphasise the benefits of a multi disciplinary approach at the frontline: *"When social care staff are working to a clear social care model and are properly integrated with the NHS, social care staff can influence the NHS model to promote different interventions. These staff then better understand the NHS model to refer people to services that can*



***Although systems are important, the action is really in neighbourhoods and places.***

*keep them independent and out of acute settings or a care home for as long as possible."*

Several interviewees also acknowledged the cultural differences between different partners as a challenge to overcome. Karl Munslow-Ong, deputy chief executive, Chelsea and Westminster Hospital NHS Foundation Trust, brought to life the vibrancy of local political context and its impact on system working: *"The politics associated with service change are often very hard to navigate, especially with boroughs', councillors' and officers' accountability for delivering change across eight boroughs, with perceived winners and losers. We made some changes, and were stymied in other areas."*

## Navigating an uncertain and complex landscape

### Diversity of approach

Given the diversity of population sizes and geographies covered by STPs and ICSs, it is understandable that the drivers for change, and the models being adopted, vary across the country – and this is reflected in the interviews from local system leaders. For example, Christine Outram, chair, The Christie NHS Foundation Trust, commented on Manchester's devolution arrangements which *"look and feel very different to elsewhere, with a much greater degree of system integration"*. Sarah Dugan and Simon Trickett described their approach to use one trust as an 'integrator' or 'host' within the system which has had to invest in building new collaborative relationships and David Pearson describes two sub-systems operating within his ICS.

While one of the benefits of system working to date has been the opportunity for local partners to shape a 'bottom up' approach to local issues, there remains a strong perception that the national bodies could communicate the desired 'end state' for STPs and ICSs more clearly. As our recent briefing on STPs set out, the diversity across the country raises questions about which models will improve outcomes and stay the course, and whether we do need a more unified approach.

### Governance, risk and accountability

Several contributors highlighted the complexities arising from a legislative and regulatory framework set up to hold individual organisations, and not systems, to account. Professor Sir Chris Ham, sums the inherent tensions up concisely: *"It is important to recognise that ICSs have no basis in law and are entirely dependent on the willingness of the organisations involved to work together. NHS trusts and CCGs have their own statutory duties and members of their boards may need reassurance that these duties are not being compromised by ICSs... Different accountabilities in the NHS and local government may also cause tension."*

Some contributors acknowledged that progress is being made in flexing national frameworks. Sarah Dugan and Simon Trickett said: *"It's taken quite*

*a brave move from NHS England and NHS Improvement to give us permission to use flexibilities to the maximum and back our system approach with flexibility on PbR and system wide performance targets."*

However, in general local system leaders were keen to encourage the national bodies to catch up to what STPs are doing locally, to enable partners to share risk and pool budgets where it makes sense to do so. Karl Munslow-Ong added: *"National bodies still see and regulate us as sovereign organisations on performance, which unintentionally undermines working across boundaries."*

### Not all roads lead to the STP/ICS

The NHS has always operated on a number of different footprints with specialised and ambulance services covering more than one STP, and key requirements around quality of care and employment delivered at organisational levels. This has been a challenge for the Christie, whose chair Christine Outram, explains that this means *"the ICS does not always provide the footprint we need."*

Leaders explained that successful systems need to look methodically at which services can be delivered at scale by the STP and which are best placed to be delivered as part of smaller local partnerships. As Sarah Dugan and Simon Trickett describe, working over large distances means they looked at how they could add value, and *"what should be done at STP level and what made sense to deliver at locality level"*.

### What drives success?

Contributors identified the following factors which drive the success of those ICSs and STPs progressing well:

#### **Strong system leadership and a culture of collaborative working**

Strong relationships are almost universally described as one of the key drivers of a successful STP. In the absence of a legal basis for STPs and ICSs, any work to integrate across a system relies on the goodwill and buy-in of everyone involved, as well as tangible efforts to join forces in service delivery. Alan Foster noted: *"One thing that really helped us in the North East and Cumbria was that we have a more stable set of organisations than in many other parts of the country. That meant that our leaders know each other. It's a real benefit and enabled us to use those relationships to move things forward."* Andy Burnham echoes this: *"It is possible to have one conversation with all the players in the same room around health and social care: a chance to get a single vision shared by everyone and to start to pull in the same direction."*

Contributors also commonly identified new skills sets required for collaborative working. Samantha Jones adds: *"As a leader, you need humility to understand you don't have all the answers."*



### **A commitment to engaging widely, with the public, staff and clinicians**

Sarah Dugan and Simon Trickett agreed: *"The real strength of [their] STP is genuine engagement – including health partners, local councils, Healthwatch, voluntary organisations, and really strong primary care engagement."*

Whereas Jagtar Singh explains the importance of meaningful public engagement: *"talking about accountable care Organisations (ACOs) and integrated care systems (ICS) is a big distraction for the public."* Instead, the focus must be on convincing the public of the benefits of working in collaboration.

### **A shared understanding based on shared evidence**

Several contributors emphasised the importance of a shared evidence base and data sharing as a key enabler underpinning shared priorities and integrated services. Samantha Jones warns: *"What continues to draw people back into organisational siloes tends to be a lack of clarity on purpose, and having no single source of truth."*

### **What next for STPs?**

Despite the variation in approach and perspectives across the country, it is encouraging that contributors commonly looked to patient outcomes as the benchmark they will use to determine how successful system working has been.



***Our recruitment campaigns will start promoting working in the NHS in Dorset, as opposed to individual organisations.***

Michael Macdonnell makes clear that collaboration and integration will remain central to the forthcoming ten-year NHS plan: *"The long-term plan for the NHS, which will be published in the autumn, will set out how we intend to catalyse [ICs] across the country, supercharging their spread. These systems are the opportunity and the vehicle for providers to be at the forefront of evolving a health service fit for the next 70 years."*

To achieve this, we need to ensure that all local systems receive the support they need to progress, identify and manage risk in new ways and through new governance structures, and evaluate the diversity of models of care emerging to understand which offer the most benefit to local populations.

### **Miriam Deakin**

Deputy Director of Policy and Strategy, NHS Providers

with thanks to  
Leanora Volpe, Policy Officer



Thanks to Andy Cowper  
who carried out the  
interviews in this report

---

# THE INTERVIEWS

## SIR CHRIS HAM

Chief Executive  
THE KING'S FUND

11



Chris took up his post as chief executive in 2010. He was the director of the strategy unit at the Department of Health between 2000 and 2004 and is an honorary fellow of the Royal College of Physicians and The Royal College of General Practitioners. In 2018, he received a knighthood in the Queen's birthday honours list for services to health policy and management.

The case for integrating care around the needs of patients, service users and populations is compelling. It is underpinned by the ageing population and changing disease burden, meaning that more people have complex needs that bring them into contact with a variety of health and social care professionals. A disjointed response to these needs is unlikely to deliver the best possible outcomes, which is why I've advocated a shift from fragmented to integrated care for over 20 years.

My views have been shaped by the opportunity to visit and learn from integrated care systems in different countries. Kaiser Permanente in the United States was one of the first, followed by Jonkoping County Council in Sweden and Canterbury District Health Board in New Zealand, to name but three examples. I've also been influenced by my work in different areas of England, including Torbay in the 2000s and more recently areas involved in developing new care models following the *Five year forward view*.

None of these systems are perfect but in different ways they illustrate why integrated care brings benefits. The biggest potential gains are better outcomes and patient experience, but also important are fewer handoffs and delays. Integration helps to reduce demand for hospital and residential care by responding to people's needs in their own homes and the community. Integrated care won't reduce how much we spend on the NHS but it should enable resources to be used more effectively.

### What's happening in England?

I've been encouraged by the work done in the new care models programme and also in the ICSs in England. The tide has turned away from competition towards collaboration, with different areas being given permission to test how to join up care for their populations. Slowly but surely, a focus on places and populations is replacing the emphasis on organisations.

All ICSs have put time into relationship building and are beginning to reap the rewards. This is exemplified by the experiences of Dorset and Surrey Heartlands where, at the end of last year, NHS organisations supported each other to hit their control totals in order to maximize the financial benefits to the system of the sustainability and transformation fund. Building collaborative relationships has been easier in some areas than others and has been facilitated by continuity of leadership and the willingness of organisational leaders to leave competitive behaviours behind.

Many of the most positive developments in ICSs are happening in neighbourhoods through the creation of integrated teams serving populations of between 30,000 and 50,000. Frimley is a good example

and it has begun to bend the demand curve for hospital care by delivering more care in the community. Parts of Nottingham and Nottinghamshire are seeing similar benefits as the investment made in new care models helps to reduce use of hospitals in some of its places.

Two good examples of place-based integration are Salford and Morecambe Bay, which were involved in the primary and acute care systems vanguards programme. Both are well ahead in the development of partnerships linking acute hospitals, community services, adult social care and, increasingly, general practices. Local authorities often have a strong identity with places, as in the Bedfordshire, Luton and Milton Keynes ICS where there are four places across the footprint.

A common challenge is to support work in places while also developing leadership and capability to work across the whole system. This has involved identifying leaders and senior staff from partner organisations to do this work and to put in place appropriate governance arrangements. ICS leaders come from a variety of backgrounds including commissioner and provider roles in the NHS and local government. All are learning what it means to be a system leader on the job.

Some ICSs are working to improve specialist services. In South Yorkshire and Bassetlaw this involves a review of how these services are delivered to a population of 1.6 million, with the aim of improving patient safety and the quality of care in acute hospitals. Dorset is also in the late stages of a review of specialist services in Bournemouth and Poole hospitals which, subject to the outcome of a legal challenge, will result in Bournemouth becoming the emergency hospital and Poole the elective care centre.

Greater Manchester had a head start on other areas as a result of its devolution deal with the government. It also benefited from receipt of £450m in transformation funding over five years. The ten areas that comprise the ICS are putting in place integrated care partnerships, in places like Oldham and Bolton, within a system-wide framework, focused on improving population health and tackling inequalities. Local authorities are key partners across the conurbation.

Greater Manchester illustrates how ICSs are beginning to take control of performance challenges in their areas. When Pennine Acute Hospitals NHS Trust was rated 'inadequate' by CQC, it was agreed that support would be provided by Salford Royal and Manchester University NHS Foundation Trusts rather than through external intervention. This work is being overseen by the Greater Manchester improvement board with involvement of both commissioners and regulators. Pennine Acute's rating has been upgraded to 'requires improvement' as a result of the intensive clinical and managerial support it has received from its neighbours.

## Barriers to progress

Many barriers to progress remain, including the provisions of the Health and Social Care Act 2012, which was drafted primarily to promote competition and which will need to be amended to align with what is now happening. The behaviours of regulators may also reinforce the focus on organisations and in so doing make it more difficult for systems to work effectively. Moves to merge the work of NHS England and NHS Improvement in seven regions may help to align the work of the regulators but leaves open the question of how these new regions will relate to ICSs.

It is important to recognise that ICSs have no basis in law and are entirely dependent on the willingness of the organisations involved to work together. NHS trusts and CCGs have their own statutory duties and members of their boards may need reassurance that these duties are not being compromised by ICSs. Local authorities are fully engaged partners in some systems and on the margins in others, often because of a perception that ICSs are an NHS invention that was not designed with local government in mind. Different accountabilities in the NHS and local government may also cause tension.

***The tide has turned away from competition towards collaboration with different areas being given permission to test out how to join up care for their populations. Slowly but surely, a focus on places and populations is replacing the emphasis on organisations.***

Concerns that integrated care may lead to greater private sector involvement have also hindered progress. These concerns arose through the use of the terms ‘accountable care organisation’ and ‘accountable care system’ by NHS England to describe what was happening, with connotations of healthcare in the United States where these terms originated. Two judicial reviews (now rejected by the courts) have challenged proposals to develop accountable care and have delayed plans to use a new contract in Dudley and the city of Manchester.

Worries about privatisation have not been helped by the lack of a clear narrative that explains why integrated care matters. Most of the work underway involves public service partnerships rather than the private sector, and starts by asking how to improve the experience of patients and service users by using staff and other resources differently. More needs to be done to communicate this and to share examples of how integrated care is already bringing benefits.

Another barrier is the pressure on organisational and clinical leaders in sustaining existing services while also investing in new ways of working. The care models established under the vanguard programme received some additional funding to support their work and this was valuable in releasing the time of the staff involved and backfilling their commitments.

The further development of ICSs would also benefit from extra resources and staff who can commit fully to their work rather than having to juggle multiple demands.

## Where next?

The prime minister's announcement of a five-year funding settlement for the NHS creates an opportunity to take forward the work of ICSs and to put more in place, as STPs demonstrate their readiness to move in this direction. The government and NHS leaders are now working on a plan for how the additional funding will be used and the indications from former health and social care secretary, Jeremy Hunt, and NHS England chief executive, Simon Stevens, are that a commitment to integrated care will be at the heart of the plan. It is essential that some of the new funding is earmarked to support integrated care rather than being used to pay off deficits.



***It is important to recognise that ICSs have no basis in law and are entirely dependent on the willingness of the organisations involved to work together.***

There is learning here from the vanguards, who received only a small proportion of the additional funding that had been promised as most of the monies were diverted into managing deficits. As the National Audit Office has pointed out, this meant that progress was slower than might have been the case had funding for transformation been protected. I've become more convinced that transformation holds the key to sustainability but it will only happen at scale and pace if it is properly resourced.

Work being undertaken in Wigan offers tangible evidence of the benefits of transformation. Under the leadership of Wigan Council, the Healthier Wigan Partnership has started to fundamentally change relationships between public services and the people they serve. The partnership emphasises the assets of communities rather than their deficits and aims to do things 'with' people and not 'to' them. Council staff have been trained to have 'different conversations' with people by asking what matters to them and listening to their concerns.

Like other local authorities, Wigan has had to make deep cuts in its spending at a time of austerity. It has done so not by 'salami slicing' but rethinking how it can best meet the needs of the population, for example by disinvesting in some services provided by the council and increasing investment in community groups. The focus is on prevention and early intervention, with the aim of reducing demand rather than managing demand.

Over a decade, population health outcomes have improved, council taxes have been kept low, and the council is financially stable. Wigan's work is underpinned by a deal with the public setting out what the council will do and what it expects of people in return. Learning from this experience,

we've argued that the NHS should develop a new deal with the public, setting out people's rights and responsibilities, and should do much more to harness the energy of communities to enable people to take more control of their health and wellbeing.

The Health and Social Care Committee has recommended that the law should be amended to align what is now happening in STPs and ICSs with the statutory framework. I agree with the committee that this is best done by asking leaders in the NHS and partner organisations to propose changes, rather than embarking on another damaging top-down reorganisation. In the meantime, it's clear that progress is possible where leaders have been able to rise above organisational concerns and work to improve health and care for the populations they serve.

Having worked with ICSs around England and observed how they are developing, I've described them as 'nascent and fragile'. Impatience on the part of national leaders and others to see rapid results is understandable given the pressures on the NHS and social care but ICSs need time to grow and mature if they are to flourish. Time invested now in building relationships and trust will repay handsomely in future if these leaders demonstrate the constancy of purpose that has often been lacking.

To return to the starting point, integrated care is not a panacea but it does offer the best hope for the NHS to improve health and care to meet changing population needs. The future of the NHS will be secured by working differently, not by asking staff to work harder. New care models, some STPs and ICSs are showing the way and patients and populations will see the results in improved outcomes and experiences, and the provision of more care in people's homes and closer to home. It's a prize worth fighting for.



***We've argued that the NHS should develop a new deal with the public, setting out people's rights and responsibilities, and should do much more to harness the energy of communities to enable people to take more control of their health and wellbeing.***

## MICHAEL MACDONELL

National Director, Transforming Health Systems  
NHS ENGLAND

16



Michael is the national director for transforming health systems at NHS England. He is responsible for integrating health systems across the English NHS that join up primary care and hospitals, mental and physical healthcare, NHS and social services. Previously he was strategy director at NHS England, senior fellow at the Institute for Global Health Innovation, Imperial College London, and advisor at the prime minister's delivery unit under Tony Blair.

The NHS just turned 70. At its inception, Aneurin Bevan predicted that the health service 'must always be changing, growing and evolving' so that 'it must always appear to be inadequate'. Since then, the NHS has pioneered game-changing innovations like MRI scanners, IVF and a revolution in mental health services, to name but a few.

As Bevan said, the NHS will need to keep changing, not least because what people need is changing too. Today there are half a million more people aged over 75 than there were in 2010, and there will be two million more in ten years' time. There are already 15 million people with chronic diseases, many of whom live with multiple conditions. People with long-term conditions now account for about 50% of all GP appointments, 64% of all outpatient appointments and over 70% of all inpatient bed days.

### Changing the model

Seventy years ago, hospital wards might have been full of people with tuberculosis, other infectious diseases and traumatic injuries. Unlike these, chronic conditions such as depression or hypertension aren't cured by a trip to the hospital, they are long-term, requiring continuity of care and joined up services that help people manage their own health. Preventing or managing these conditions requires services to get upstream, ultimately supporting people to alter the unhealthy behaviours that cause or exacerbate them.

This is what integrated care means: the NHS and local government collaborating to provide joined up services that are 'anticipatory', with the aim of preventing ill health or unnecessary hospitalisation.

The 14 ICSs across the country are beginning to do just this. Systems like Frimley and the Fylde Coast are reconnecting GPs and consultants, joining up teams working in surgeries and hospitals, resulting in reduced referrals and non-elective admissions. In Buckinghamshire, GPs collaborate to prevent avoidable hospitalisation, re-investing funds from QOF to support proactive care. To further hasten the integration of primary and community care, providers and commissioners in Dorset collectively took the decision to invest £6m recurrently, re-allocating system funds to support a new model of care. In the vanguard systems, between 2014/15 and 2017/18, growth in emergency admissions has been held to an average of 0.9%-2.6% per person whilst in the rest of country they have increased by 6.3%.



## A common architecture

We have learned from these 14 systems that integrated care has a common 'architecture'. At the neighbourhood level, primary care networks collaborate to improve general practice resilience, share staff and assets and provide proactive, multidisciplinary care to populations of about 50,000. At the place or locality level, often coterminous with district/borough councils, acute providers integrate their services with primary care networks, local government and mental health around those patients that could be kept out of hospital and empowered to look after themselves better. Systems, serving populations of about 1m or more, take overall responsibility for improving services within their share of NHS resources. They foster 'horizontal' collaboration between providers and shape the provider landscape. They develop system strategic and operational plans, including for infrastructure like digital and estates.

## The role of providers

Providers must be at the heart of this work. Integrated care is not about structures, the wiring behind the scenes or even money flows. That's why, although systems are important, the action is really in neighbourhoods and places. This is where the hard but exciting work is done to (re)connect clinical teams across traditional organisational and professional boundaries. Neighbourhoods and places are where providers, GPs and social services collaborate to develop proactive services for those people most at risk of getting acutely ill.



***Providers must be at the heart of this work. Integrated care is not about structures, the wiring behind the scenes or even money flows. That's why, although systems are important, the action is really in neighbourhoods and places.***

ICs are the direction of travel for the NHS. Their development is in response to ageing and epidemiological trends common across all advanced economies. The long term plan for the NHS, which will be published in the autumn, will set out how we intend to catalyse them across the country, supercharging their spread. These systems are the opportunity and the vehicle for providers to be at the forefront of evolving a health service fit for the next 70 years.

## ALAN FOSTER MBE

Lead CUMBRIA AND NORTH EAST STP/ICS  
Accountable Officer  
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST

18



Alan Foster was appointed chief executive in September 2007. Born in County Durham, he is committed to improving services and the quality of life for people in the north east of England. He was awarded an MBE for services to the health service in 2013.

Our starting point was to agree the key principles for working as a system. From our perspective, it was about putting patients first and protecting frontline services as far as possible. We also wanted to preserve local clinical leadership and autonomy as far as possible. Coming together to develop integration was basically a means to those ends.

We acknowledged that we would have to respect the NHS legal framework but, in fact, there was already local integration work under way – the local authority’s place-based approach, the health and wellbeing board (HWB), prevention and joint working methods – and we wanted to preserve and build on this.

Local relationships are the key. Changing organisational structures takes too long to deliver anything meaningful, so it has to be about collaboration.

We felt there were some things we could do more effectively and efficiently at system-wide level. We had already made progress here with good clinical networks and joint services, and we were keen to protect that.

### Walking the walk

It’s easy to ‘talk the talk’ of integration, but we must ‘walk the walk’ locally and in terms of national policy making.

Locally, we still see evidence of the systemic barriers between commissioners and providers, but ultimately patients must be at the centre of what do. That can only happen if we work together to make the best use of resources, which requires a common message from the top to incentivise the right behaviours. We need that joined-up approach across the system leadership board.

NHS England and NHS Improvement have now recognised there was, at times, a lack of coherence between them, and have started sharing non-executive posts. They need to speak with one voice and Ian Dalton, chief executive of NHS Improvement, has talked about that greater alignment, which we welcome.

We also need much better nationally-led messaging and communications for colleagues in local authorities. If health and social care come together under Matt Hancock, as the department’s name change implies, this could be another significant step towards putting more focus on social care funding and aligning messages. Joining up health and social care at each level of the system is important.

However, we’re making progress. The new planning guidance allows us to take forward a strategic planning exercise across organisational

boundaries, to develop more strategic approaches and to use vanguard projects as models for how to support delivery at the frontline for the wider STP.

### A collaborative approach to workforce planning

A move towards looking at population health management and developing workforce plans is vital – both of these must be done system-wide. As a health economy, historically, we've been using staff from the same pool due to a lack of skilled people, especially on the provider side.

Instead of undermining each other in that way, we now network to sustain services across our footprint and meet the seven-day NHS challenge on weekends and bank holidays. We can still do some of this better at scale but we are keeping sight of the fact that the main benefit for patients is local health and social care integration. The general public is not interested in who employs their doctor, nurse or social worker, or if the service is voluntary, as long as it's joined up.

This is another point for the arm's-length bodies to consider – devolving the workforce planning agenda to STPs could be very helpful.



***The general public is not interested in who employs their doctor, nurse or social worker or if the service is voluntary – as long as it's all joined-up.***

### Building on stable leadership: stable organisations

A factor that helped us in the north east and Cumbria was that we already had an existing stable set of organisations, more so than in many other parts of the country. Our leaders already know each other, a real benefit, which enabled us to use those relationships to move things forward. I'm not saying any of this is easy, it isn't, but that was a helpful base from which to start.

By national standards, on some targets (four-hour A&E targets and cancer treatment times) we do relatively well, but we always want to stay ahead of the game in delivering the best services we can for local people.

### Getting the right incentives

We still see trusts seeking to maintain a degree of independence on the issues which they are judged externally by the national bodies. This understandably includes finance, performance and recruitment and retention issues. We have to incentivise the right behaviours as a national health and care system.

There are real consequences for individual leaders and organisations taking the risk to effect change which is collaborative and delivers better services for patients. That cannot be right. There are still big financial consequences for trusts if they try to manage demand and provide

more services in community and home settings. If that proves successful and drives less activity, or activity in cheaper settings, it still affects a trust's bottom line and if their financial position deteriorates, that has consequences which can be hard to manage. Likewise, there are heavy sanctions for breaching the agency staff bill or overspending.

The national bodies want to see change driven locally but if that change knocks a key performance target off the beam as a consequence, in my experience there's not a lot of forgiveness.

We need to get a common understanding of 'doing the right thing'. The local system overall should benefit from initiatives to collaborate and integrate care, but the financial consequences may well sit in different places. For instance, CCGs could benefit while providers lose but overall if patients benefit, it is the right thing to do. Maybe it's time to move from tariff-based payments to something more intelligent, which will incentivise the right behaviours. We have to find the right currency or compensate each other when change drives financial loss.

### What does the future hold?

If STPs/ICSs prove successful, digital transformation will have played a big part. I'm a believer that technology can help us move at pace and transform how care is delivered – phone apps, sharing records, interoperable systems, telemedicine and telehealth at scale out in communities will all have a part to play.



***The national bodies want to see change driven locally, but if as a consequence that change knocks a key performance target off the beam, there's not a lot of forgiveness in my experience.***

There is so much we can do and should be doing. I foresee people being able to manage their long-term conditions much more easily using apps and having phone conversations with specialist nurses remotely to help manage their own conditions. Similarly, technology can make a big difference to frontline clinicians' ability to make a quick, safe and accurate diagnosis.

In the future, I can see airline style check-in to hospitals. Patients will put in their own data, register themselves, make e-appointments and e-book with GPs. Delivering care to patients through technology should be quicker, safer and provide better access.

The digital capital fund will help but we should also give exemplar trusts a remit to roll things out across wider footprints, which will enable it to happen more quickly.

This is one area where I would support greater direction and a mandate from the centre. Things could be improved by using mandatory and licensing regimes in order to spread good practice more quickly for the benefit of local people.

## DAVID PEARSON

Deputy Chief Executive NOTTINGHAMSHIRE COUNTY COUNCIL  
Lead NOTTINGHAM AND NOTTINGHAMSHIRE ICS

21



David became deputy chief executive, with responsibility for public health in 2008, after working in social care for over 30 years. As president of the association of directors of adult services, David continues to work with ministers on implementation of the Health and Care Act and integration with health. David was awarded a CBE in the Queen's birthday honours list in June 2016 for services to adult social care.

When it comes to integration and working as a system, we have examples of strong innovation and some fantastic work across a range of services. We have two sub-systems within the ICS – developing integrated health and care models which work for their local populations, bound by a common purpose and determination to better meet the health and wellbeing needs of our rapidly changing population, and stretching the public purse as far as we can.

### Joining up data and information

One of our key enablers of change has been driven by the local digital roadmap initiative, which predates STPs. *Connected Nottinghamshire* is perhaps one of the most advanced of these initiatives in the country and reflects extraordinary work on integrating information systems across health and social care.

We have a data warehouse, a GP repository for clinical care (GPRCC), which has half a billion patient/citizen records. Each day, a million records are updated. One hundred percent of GPs signed up to the data sharing protocols and can provide not only integrated records, but also pseudonymised data. As a result:

- The portal is now used to access records 4,300 times a month and is increasing month on month across Nottingham University Hospitals. Approximately 20% of emergency department patients GP records are now checked, with imminent plans for mental health data to go live.
- Urgent and emergency organisations from 111 and ambulance to GP federations and out-of-hours providers are now using record sharing every day, with around 33,000 records accessed every month.
- GPRCC continues to grow every day, identifying to the care coordinators where interventions need to occur – 5,000 patients a month are now benefiting from more proactive care. This is constantly evolving and may help to play a part in the development of the national algorithms for social care risk stratification.
- Requests for assessment are now semi-automated, bringing the time taken from four hours to approximately 30 seconds. This happens 365 days a year, without the loss of time over weekends and holidays.

Of course, you need to make the system proportionate and relevant. There has been some particularly innovative work at two of our hospital trusts, which means the end of paper transfers, so all data can be shared in real time.

We can extend this to our care home pilots, and across the whole sector.

### Primary care integration

Secondly, we have a range of multidisciplinary teams in primary care. People think integrated care is in some way new. It has been happening

in pockets, but it's not been applied systematically either to the cohort of our population as a whole, or in the community of primary care.

We should focus on the population who are at most risk of needing hospital or residential care and develop a co-ordinated approach to provide support and manage risks.

### Integration can save money – if the model is right

We received Local Government Association funding to research multidisciplinary work. Looking at what had been published previously, we found next to no evidence that integration really saves money.

The research we have done locally suggests that if you get the model right, integration does save money as well as improving the experience and outcomes for the population. That's quite exciting.



*People think integrated care is in some way new. It has been happening in pockets, but it's not been applied systematically either to the cohort of our population as a whole, or in the community of primary care.*

We worked on three broad multidisciplinary models for primary care in Nottinghamshire. The research found that two of these have been improving outcomes for citizens and saving money for health and social care. They provide effective person-centred coordinated support and enhanced choice and control and can help to give those people needing care the best help we can. We are building on this through the integrated personal commissioning pilot, where in 18 months we have gone from 85 personal health budgets to nearly 2000. Of these, 500 have been integrated health and care budgets, putting people with long-term conditions in control.

There is some evidence that, in fact, if you don't get care integration and co-ordination right, it certainly costs social care money and if you don't have the right health intervention, it increases social care costs. Looking at fall prevention as an example, historically, 40% of people who have a fractured hip end up in a residential care home.

The fact that one of the models of multidisciplinary working didn't realise the benefits is important. The model of integration matters – it's more than just putting people from different disciplines into the same room around a pooled budget.

Previous national policy was based on the idea that pooled budgets and integrated structures would make the difference. That proves not to be true: the integration model matters most.

It seems to be the case that when social care staff are working to a clear social care model and are properly integrated with the NHS, the staff can influence the NHS model to promote different interventions. These staff then better understand the NHS model to refer people to services that

can keep them independent and out of acute settings or a care home for as long as possible.

In mid-Nottinghamshire, the local integrated care teams also based their approach around this, with other interventions and shared set of outcomes across health and social care. This is critical.

Agreeing the outcomes across health and social care that matter, not just within each sector's silo, with meaningful measures of a good integrated system enables the sharing of objectives and a common purpose. It made a major difference in mid-Nottinghamshire to how people see admissions to residential and nursing homes, which we subsequently reduced by over 20%.

### Start small and scale up

The STP process acknowledges that much more prevention is needed through the NHS itself and that the public is generally not sufficiently involved. Public health does get involved in the STP processes, but I'm disappointed that the funding is not there to implement what is

needed. So much more could be done to improve efforts around prevention, be it primary, secondary or tertiary. For example, with alcohol-related harm we have strong evidence on the benefits of alcohol liaison teams and targeted, focused efforts in acute and community settings. Unfortunately, rather than scaling these up, they're being cut back, which is short-sighted.

As for smoking, I think every patient with a smoking-related illness should have access to a brief intervention and support to stop smoking. That should be standard across the NHS, as should encouraging healthier habits in physical activity and diet.

We have to work with patients and communities to improve people's understanding of their risk factors and what they can do to improve their own health and wellbeing. We need to empower them.

### Thinking sustainably

We have benefited and learned from scaling up smaller pilots, including our involvement in the vanguard programmes. Last year we saw a 23% reduction in hospital admissions from relevant care homes within the vanguard area.

Through our ICS, we have been spreading this approach across the city and county and we implemented it in Mid Nottinghamshire, where care homes have seen a 13% reduction in emergency admissions so far.



***Previous national policy was based on the idea that pooled budgets and integrated structures would make the difference. That proves not to be true: the integration model matters most.***



Another example would be the potential to improve outcomes and efficiency through joint commissioning. Our community equipment contract is with a third sector provider – this issue illustrates how hard it is to do integrated commissioning, but how valuable to get it right using a pooled budget and common contract across seven CCGs and two councils.

Practices around use of community equipment were very different between health and social care, and the reutilisation of equipment was extremely inefficient.

Some areas took a more a proactive approach and did more on collection and recycling. Gradually, everyone has moved and developed a more robust and consistent approach to understanding what intervention makes a difference, reducing variation.

There has been a 10% rise year-on-year in the need for equipment since 2004. The budget for the service has remained at £7.3m for the last five years, but we have saved £1.1m on our budget spend. Due to the service model and efficiencies, the service actually handles £25-30m of equipment each year, with 95% of equipment being recycled back into use.

This is not rationing, it is simple efficiency and recycling, and we have case study evidence.

This exemplar shows that despite this being hard work and involving tough discussions and the culture of change, if you monitor money and spend and work with external providers, as well as motivating staff to get kit back for repair and renovation, the impact is huge.

## Looking to the future

If STPs and ICSs prove to be successful, in five to ten years' time the population will have benefitted from the different strengths of the NHS and local government working together. The NHS has, for the past 70 years, been good at keeping us well and helping us live longer. Social care, when properly funded and working well, delivers person-centred, co-ordinated care with and for people with long term conditions or disability. We need to join this with other public services and interventions in the local place. Housing is crucial but so are other public services and the community and voluntary sector.

It will mean person-centred, coordinated care, and living well independently with long-term conditions. It will mean a system that aims to prevent illness, from primary to tertiary prevention, from childhood obesity to end of life care. It will mean a system that addresses the needs of informal carers, who are worth £120-139bn to the UK's health and care economy.





***We need a clearer longer-term plan for direction and funding, so we're not lurching from spending review to spending review – we need the longer-term view on how this is to be paid for, operated locally. That is a huge issue for social care right now.***

The enablers and system design will have interdependencies around financial outcomes, performance and quality, so we will be looking at a whole system in a local place. And there must be a better balance between local and national bodies, supporting and enabling local responsibility, as well as accountability.

We need a clearer, longer-term plan for direction and funding, so we're not lurching from spending review to spending review – we need the longer-term view on how this is to be paid for, operated locally. That is a huge issue for social care right now.

## SAMANTHA JONES

Former Director, New Care Models Programme  
NHS ENGLAND

26

Having worked nationally, I am now in the privileged position of working with colleagues in different parts of the country.



Following posts as chief executive of both Epsom and St Helier University Hospitals NHS Trust and West Hertfordshire Hospitals NHS Trust, Samantha now works independently with the care sector supporting the delivery of high quality population healthcare. Samantha was also the director of the new care models programme until 2017, leading on the implementation of the new care models outlined in the *Five year forward view*.

Over the last few months, people are starting to work out how best to operate together across their systems to identify and address the health and care needs of their population.

For example, Oldham has been doing really interesting work with their local authority leaders, taking responsibility for commissioning, with a strong focus on the wider determinants of health, and working closely with a range of local providers, including the voluntary sector.

Nottingham's ICS has strong primary care leadership and the partners in Nottingham have been working together to understand how the variation across the local population can be addressed in practice. As a result, they are giving significant thought to how the health economy can deliver improved care.

### Technology, data and variation

I'm slightly frustrated that this work is not moving faster, particularly around integrating technology. I recently visited Israel and they are much further ahead in this regard. They use a model of care with effectively four similar-sized health maintenance organisations, underpinned by strong technology. All Israeli citizens have their health data on their phones and there's a 'single source of truth' patient record. They use this technology to address care variations.

In Israel, healthcare is predominantly primary care-driven. Nurses can easily move between organisations depending on their personal circumstances, and the environment and systems positively enable that to happen.

My personal learning is to invest in the data. Once you can target variation, then your work to address it can start.

You need to understand variation at system level, and target resources around it, it can't be done any other way. This work needs leadership, consistency and an understanding that it's hard and our current system infrastructure and architecture does not support it. Asking supporting staff to do this is a significant leadership challenge.

### Collaborative leadership; collective working

Be confident you've got the right partners around the table – not just trusts and CCGs but local authorities, carers and the voluntary sector. Don't get caught in arguments about governance, organisational form



*I hope we will be able to show that we've made great strides in fundamentally changing the way we work together and improving population health as a result. That is the important thing and I think we'll get there, whatever the structure and architecture is called.*

and templates, but do be clear how decisions will be made. If you're clear about this, people in your system can have confidence.

You need trust to be fundamental to your system's relationships, with everyone understanding that all parts of the system have their part to play, and able to articulate what that part is.

What gets partners on board to work as a collective? In my experience, it's resilience, leadership, focus and having the courage to know that you're doing the right thing.

As a leader, you need humility to understand you don't have all the answers. You need to be confident enough to challenge up the line when what is happening is not consistent with the messages given.

When I was an acute trust chief executive, I didn't know what I didn't know – where was the support to show me with data and shine a light on things? Humility is going out and finding that support, but you have to start with knowing what you don't know.

Conversely, what continues to draw people back into organisational silos tends to be a lack of clarity on the purpose, and having no single source of truth as those with vested interests in a system don't want one.

## Getting the incentives and enablers in place

There's a lot to do to shift the NHS towards a coherent set of incentives for collegiate behaviour but we're getting there.

A few examples:

- look at where we need to be from a workforce perspective – staff will need to be able to move in and out of NHS and local government/social care organisations seamlessly and without being penalised on pay, terms and pensions
- similarly, primary care needs investment to strengthen it and reduce fragmentation – all parts of the system have to be strong, with the end game in mind of better care.


## The future

What will this look like in five years time? I really hope we are not talking about these issues of data and integration in five years. I hope we will be able to show that we've made great strides in fundamentally changing the way we work together and improving population health as a result.

That is the important thing and I think we'll get there, whatever the structure and architecture is called. I hope we will be able to show we fundamentally changed the way we deliver and commission care.

Looking across the system, the use of data and technology will be ubiquitous to detect UTIs or predict cancer with artificial intelligence.

We have this ability now. The arc of history means that we need to shift how and where we provide care even further on the basis that technology will fundamentally change the way care is provided.



***You need to understand variation at system level, and target resources around it. You can't do it any other way. This work needs leadership, consistency and understanding that it's hard and our current system infrastructure and architecture does not support it.***



## SARAH DUGAN

Chief Executive WORCESTERSHIRE HEALTH AND CARE NHS TRUST  
Chief Executive Lead HEREFORDSHIRE AND WORCESTERSHIRE STP

## SIMON TRICKETT

Accountable Officer NHS SOUTH WORCESTERSHIRE,  
NHS WYRE FOREST, NHS REDDITCH AND BROMSGROVE CCGs



Simon is an experienced public sector leader who has worked in several large organisations in communications, business and strategy development and customer services roles. Simon has worked for Worcestershire County Council and has held director posts in NHS provider and commissioning organisations.

As well as a chief executive, Sarah is a registered general nurse, sick children's nurse and health visitor. She has a Masters degree in health and social care management and has held a wide range of senior positions within provider and commissioning organisations, with a particular interest in partnership working, integration and the development of positive learning cultures.

The STP has been in operation for two years now, and at the beginning it wasn't a particularly natural way of working.

Herefordshire and Worcestershire have similar rurality but, due to geographical distance, the two counties hadn't worked together in any significant way and patient flow across the two counties was limited.

Much of the early work of the STP was about building relationships, deciding what we should do collectively and what delivers more value by remaining local. Because of the geographical scale and distances over which we work, there is a very strong desire to maintain a sense of place at county level. This meant that we needed to undertake further planning, focus on added value and think about what we should do at the different layers of planning – what should be done at STP level, what should remain at each county level and what made sense to deliver at neighbourhood/locality level.

What's different (and wouldn't have happened without STPs as the enabler) is the sense of cooperation and collaboration. It's surprising how cohesive it has become, encouraging all partners, commissioners and providers to work together on common, shared issues and collective solutions makes for a really effective joint approach.

Our approach is for all organisations (including the council) to collaborate in decision-making, and our style is consensual. Now, one accountable officer is in charge of the three Worcestershire CCGs, which helps simplify things further. Having the chief executive of a mental health and community trust take up the STP lead role was largely because, in the context of a lot of change, Sarah was one of our most respected senior leaders, had been in post a fair while and knew colleagues and the population. It was a pragmatic decision and the right decision.

An example of our collaboration was the 2017/18 winter plan. This had staff from organisations across our area working in other organisations, putting aside the divisions of commissioner and provider to work together as one team. Two years previously, that would have been unimaginable.

### Full and wide engagement

The real strength of this STP is genuine engagement – including health partners, local councils, Healthwatch, voluntary organisations, and really strong primary care engagement. In the early days, we invested time

in those relationships, working out how to enable primary care to get involved, develop a co-ordinated approach and let independent practices feel they have a say and are enabled to contribute.

Our local medical committee (LMC) has been extremely co-operative and supportive. Our STP chose to have both LMC representatives and the GP ambassador from the Royal College of General Practitioners locally on board from the start. They have done a lot to galvanise the voices of primary care, and that is really paying off. There's a sense we really are all in it together, and a real strength from having strong non-statutory body input and a lot of support from the councils, as well as cohesive support from primary care.

Having lived through five to six years of CCGs, it's clear that GP practices are more engaged in this approach to integrated care work than they probably ever were in strategic commissioning (perhaps because GPs understand population health). The level of engagement is much more evident – they see our neighbourhood team approach, they understand it and embraced it and are actively leading it moving forward.

In designing our neighbourhood teams in Worcestershire, we went to see the Buurtzorg Nederland and Swedish models to learn how they empower clinicians to reframe the ways in which they offer care to make it truly patient centred.

## Supportive relationships

If you achieve supportive and positive relationships, a lot more follows. Given our history as a challenged health economy, we had well-known issues around finance and care quality. If we'd had the performance of a more stable health and care system, there might have been no incentive to drive this. We knew we needed to change.

NHS England in the West Midlands had a very proactive approach. They devolved some of their team to STP level, and we subsequently integrated their staff with our STP programme management office. That has helped cut layers, reduce duplication and given us access to their experience. They are used to overseeing change and delivery on this large scale.

## Enablers of progress

Transformation is more feasible when you are able to double-run services with pump-prime funding for new services. We knew we would have to work hard to free up financial and staff resource to make this change happen. Autonomy is another significant enabler. NHS managers are trained to follow instructions and guidance but to progress with this new system based approach we need more autonomy and permission to work differently.



***What's different (and wouldn't have happened without STPs as the enabler) is the sense of cooperation and collaboration. It's surprising how cohesive it's become: encouraging all partners, commissioners and providers to work together on common and shared issues and collective solutions makes for a really joint approach.***

It has helped that we've been encouraged to go at the right pace for us. Relationships are also important. Nationally, we still face very tight deadlines, but getting the right people involved and committed takes longer, as does buy-in from primary care and across a bigger system. All of this needs flexibility and trying to do this in 12-18 months wouldn't be realistic.

As for resources for support, as a challenged system we can't pile in a lot of extra people or commission more support. We can't afford new leaders so we have to re-align people's day jobs to STP priorities, work together and stop duplicating as a set of organisations. This has resulted in greater ownership of the changes.

This winter, our commissioners and the STP management team shared the workload and agreed common messages. If one organisation prepared a staff message about winter issues, all organisations in our system used it. That's one practical example of people sharing the load.

With relationships in a better place, there is a greater sense that this agenda is everyone's issue and priority.

## Barriers and challenges

One challenge has been specialist acute services. With circa 800,000 residents, there are some things we can't sensibly do in our STP, we have to partner with other STPs.

We started with a small list of services that we needed to provide once at STP-wide level. Now, we're developing a list of more specialised services which we can work on with other STPs. For these, we have to look outside of our own boundary. The right size of STP can be irrelevant if you approach it creatively, thinking about what changes you need to make and who you need to work with to deliver.

We still have significant performance issues. We are increasingly taking collective responsibility and working on how we support each other in performance and quality improvements. As an STP, we can have better oversight of system outcomes, performance and an understanding of the challenges and creative solutions. Having written our plan, we take collective responsibility for our system. One of our acute providers has a significant £60m operating deficit, while others have smaller deficits and some have surpluses. Getting surplus providers to consider the option of shared control totals is challenging; they are financially prudent and understandably nervous of losing any pooled money forever.

This raises broader national system-level challenges. Planning guidance has been helpful but there remains a tension between a board's

responsibility and accountability for its own organisation and delivery, whilst also being asked to look to more collective responsibility for the system.

## The integrator approach in Worcestershire

Part of our work now is to find a way to get to being an ICS with collective responsibility. How can we grow the trust, confidence and oversight needed, while keeping organisational accountability and responsibility? We all buy in to the integrated care vision but don't yet have the mechanics of getting from A to B safely, which we need to provide assurance for our board members around the safe transition process.

Our STP is adopting a model in Worcestershire, where Worcestershire Health and Care NHS Trust becomes a 'host' for integrated community and primary care in Worcestershire for a period. Initially, some people felt nervous about the concept of local alliance boards and collective decision-making but we are now seeing the benefits of this way of working at neighbourhood level.

We decided that we needed a more formal but different way to get to an integrated care model and thought that using a local organisation in the NHS infrastructure could work well. When you look at the impact of VAT, regulation, liabilities and employee terms and conditions, it seems as if you need an NHS trust infrastructure to host it all and enable the change.

Procurement laws still apply, so we formally adopted the model for a pilot period of 18 months to two years, and, following an option appraisal, the CCGs gave permission for Worcestershire Health and Care NHS Trust to be the 'home' the new model would be built around. We agreed to go ahead in October 2017 and have been adapting the governance to make that work. It looks like our approach is going in the right direction.

The Worcestershire Alliance Board has been running for almost three years. It was created to work closely on integrated care, partly based on co-production with people with complex needs, but we found its services fragmented.

Our working groups brought professional staff from social care, the combined community and mental health trust and primary care together to co-produce and co-design our new neighbourhood teams. We got to the next level through collaboration, co-design and an alliance model. Teams want to work in integrated ways but when staff come from separate organisations it becomes more complex.



***Nationally, we still face very tight deadlines, but getting the right people involved and committed takes longer, as does buy-in from primary care and across a bigger system. All of this needs flexibility.***





***Social care staff are aligned to these teams and we have really benefitted from an integrated leadership approach, this helps to deal with the differences between NHS and Council policies, and terms and conditions.***

## A host, not a takeover

This area has always found it hard to deliver acute care because of its rurality and the distance patients have to travel and because there isn't a tertiary acute trust. We therefore built our plans to take advantage of our strengths, and existing infrastructure, in community and primary care through the alliance approach.

Social care staff are aligned to these teams and we have really benefited from an integrated leadership approach. This helps to deal with the differences between NHS and council policies and terms and conditions and bringing them together under a single team leadership meant we didn't have to TUPE (transfer of undertakings [protection of employment] regulations) them to various NHS trusts. It could also enable co-location and collaborative working whilst ensuring an underpinning governance structure. This is one example of what the trust does as a host integrator.

We also addressed primary care's anxiety about core contracts – this enabled them to engage and provide leadership. This concept is not about organisations taking over anyone else, it's about finding ways to enable integration to happen quickly. If you aren't careful, process can dominate. We've got much further by getting clinical teams talking to each other more and co-designing solutions, this gets things moving. Our economy has done well on admission avoidance and supporting end-of-life care at home.

## What will success look like?

If integration proves successful, our population should see a much more seamless, joined-up offer.

Success would mean acute specialist clinicians working with community teams outside hospitals, providing advice and guidance to our neighbourhood teams to enable better care and outcomes for local people.

Success would involve more co-production with patients and service users helping to redesign services and using more innovative digital technology. As this develops, we should see the growth of self-care and increasing individual resilience as people feel more in more control of their own condition, assisted by the right support when it's needed.

## CHRISTINE OUTRAM

Chair  
THE CHRISTIE NHS FOUNDATION TRUST

34



Christine became chair in 2014, and has worked at board level in the health sector for 24 years. Chris is also an elected board trustee of NHS Providers, as well as a non-executive director of the Yorkshire Academic Health Science Network. Her first role in the NHS was as a patient advocate and she continues to be passionate about working with clinical staff and patients to provide excellent services and outcomes for people.

I am chair of a specialist cancer hospital in Greater Manchester, which provides a networked specialist cancer service to our three million patients in Greater Manchester and Cheshire.

### How DevoManc helps

Health and social care have devolved accountability and funds to a pan-Manchester body, DevoManc. This looks and feels very different to elsewhere, with a much greater degree of system integration. This is helpful as it means everyone can see local autonomous decision-making on behalf of the population. People have always tried to work together, but the interests of individual organisations sometimes dominated strategy. Being part of a collective project means people try hard to make it work and DevoManc gives us some structure and infrastructure to enact change.

Of course, our local authorities within Greater Manchester are also extremely engaged and that is a key enabler. Our strategic partnership board is chaired by a local authority leader and meets every month. This is attended by every chief executive and council leader, with much focus on local authority work and prevention and public health working alongside the NHS.

### A tertiary perspective

CQC describes our trust as an international leader and we aim for precisely that in our quality of care, research and teaching. Vitally, we are able to integrate all three, which we see as the hallmark of a truly world leading centre.

We are strongly linked with other acute providers and primary care, within Greater Manchester and nationally. Our networked approach means that our specialist services can be made available nearby to wherever patients live.

We would like more cancer patients to be diagnosed early, as that will mean better success in treatment. To be truly world beating, we have to work together with others so that our patients, whether treated at The Christie or elsewhere, have the best possible care and the best chance of successful treatment.

### Catalysing change

Local relationships didn't start with DevoManc. There is a long history of co-operation around Manchester. When the previous cancer networks were abolished by the Lansley reforms, we maintained co-operation through establishment of Manchester Cancer as part of the Manchester Academic Health Science Centre. This gave a real focus on improving cancer care pathways between providers and evolved into the cancer



***Everyone can see local autonomous decision-making and taking charge of decision-making for the population – people always tried to work together, but the interests of individual organisations sometimes dominated strategy.***

programme of the new devolved authorities, as well as being the basis of the northern part of the national cancer vanguard. This was the springboard for trying out new and innovative ways of prevention and early detection of cancer in some of the worst affected parts of Greater Manchester.

Now, the DevoManc partnership can build on that history of collaboration and offers us a good organising structure. We have an agreed cancer strategy and a number of innovative programmes within the framework of the national cancer strategy.

It's sometimes hard to separate the Greater Manchester partnership and what we would have achieved anyway. In the end, however, people here naturally want to make good things happen and co-operate because they see the sense in trying to be successful. There's a certain pride here that Greater Manchester has gone further than some STPs – organisations and staff are making things happen at system level.

## Not all roads lead to the ICS

Of course for a specialist trust, as for many providers, the ICS does not always provide the footprint we need. The Christie leads innovation in many areas for the North of England, and the country more widely, for example we have recently been designated as an advanced cellular therapy research centre.

We have partnered with industry for pioneering work on stem cell therapies and will be one of only three centres for this in England.

We're also bidding to be a regional genomics centre, and have five STPs across the north west involved. Greater Manchester is working with other STPs to agree how to do genomics together – STPs provide an easier basis to agree this than trusts working alone.

## Public and clinical engagement

We have fantastic clinical and public engagement through Greater Manchester Cancer, before the ICS came about. Previously, we could get networks of clinicians to work together better. Now we have vehicles like the cancer vanguard to support important changes, such as improvements in treatment pathways or offering CT scans in supermarket car parks in order to detect cancer early. All are captured within our cancer strategy. I would say we have good engagement compared with other places. People are quite knowledgeable and connected.

As you would expect with local authority involvement, public engagement has been a core strength. For cancer care specifically, we have recruited thousands of ‘cancer champions’. We work with them on what can change public behaviour on eating and drinking. This way, the public pass on their knowledge – it’s innovative and works well. Foundation trust governors are also important in supporting us to engage the public.

### Looking to the future

If STPs/ICSs and DevoManc prove successful, in five to ten years time we will have improved cancer prevention through more collective endeavour and better early diagnosis. We all see that as key to improving.

As well as improving outcomes, we will have also settled any changes in cancer care pathways (route, standardisation, good practice on tests, where expertise is best concentrated). Making collective decisions is vital to all those improvements and I’m now more confident we might be able to do these things and make it all happen.



***We have recruited thousands of cancer champions. We work with them on what can change public behaviour on eating and drinking. This way, the public pass on their knowledge: it’s innovative and good.***

## KARL MUNSLOW-ONG

Deputy Chief Executive  
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST

37



Karl joined the trust in 2015 as chief operating officer, becoming deputy chief executive in 2016. He has extensive operational management experience across a number of acute London trusts and in his previous role was the executive responsible for the clinical divisions, strategy, service transformation, major incident planning and contract management.

In a big, urban environment like London, we have to deal with the added complexity of the sheer number of stakeholders in our STP.

There are eight CCGs, eight London boroughs, eight provider trusts and many other parties.

It feels incredibly difficult to make and agree change, and it's a real challenge for north west London to initiate transformative change with that number of stakeholders.

### Scale and stakeholders

We have better examples at a more local level in our constituent boroughs, where boroughs and CCGs are in close co-terminosity and there are fewer stakeholders.

The London borough of Hillingdon's health and social care services are working on integration projects to better align care. Our best example of this is our work with the London borough of Hammersmith and Fulham on accountable care.

There is other work based around boroughs. For example, together with Imperial College Healthcare NHS Trust, we work with community and mental health services, the third sector and GPs – which is complex. Despite the sheer number of different contracts, there's a willingness to work together and develop things.

Where we have been most successful in any integration project has been where there are fewer stakeholders, and it has tended to be in provider-to-provider interactions, with more established providers.

This could be because these providers are experienced in governing more complex organisations and more complex governance structures, than, for example, GPs. We have good examples of integration and partnering projects, but they are all provider-to-provider. This doesn't mean that new collaborations aren't possible or necessary, it is just that we need to ensure the conditions are right to help make these work.

### Incremental pace

However, this is not happening at a fast pace. Much of it is about developing our relationships and mutual trust to develop new models of care.

We're trying to develop proof of concept in Hammersmith and Fulham. We now have a memorandum of understanding and a broad non-legally-binding contract – a firm written commitment of partnership.

This written commitment is a good step forward. The question is, if this becomes more evolved would we think about formally becoming an ICS? I think it's questionable. The largest acute providers are ourselves



***Where we've been most successful in any integration project has actually been where there are fewer stakeholders, and it tends to be provider-to-provider and with the more established providers.***

and Imperial College Healthcare NHS Trust and we both have significant interests in five different boroughs. Would we end up having five different ICSs in five different boroughs with five different providers?

That would not seem sensible, and perhaps not legal. A large acute trust needs to think about a way of operating with some uniformity and manageability. Imperial have an even bigger brief, a £1.2bn turnover and an even bigger catchment.

## Legislative and regulatory tensions

Some conversations I have with colleagues in the national bodies and the regulators bring out the legislative and regulatory tensions. Larger-scale change to legislation and regulation must lie ahead.

National bodies still see and regulate us as sovereign organisations on performance, which unintentionally undermines working across boundaries. I can think of recent examples where procurement rules and market mechanisms inhibit more collaborative efforts, in a number of instances.

One example is our joint venture on pathology services.

We made the case to the CCG that pathology is a key support service underpinning system working, it supports healthcare in all settings, from GP to diagnostic, secondary and advanced services. However, we've found that the CCGs felt legislation required them to do a full market test, rather than thinking about pathology across this whole health economy. Sadly, they have awarded the contract to an organisation outside of north west London on the basis of price. In my view, this fundamentally undermines the idea of trying to develop a model of scale and uniform delivery across the patch.

Some things can help bind an integrated system together, and pathology is one classic example. It's an underpinning element of an integrated service model.

## Local authorities, public engagement and the politics of change

The relationship with local authorities is clearly complex because there are so many. North west London was a pre-STP pioneer, working collaboratively with local government on big strategic change projects.

However, we courted a lot of controversy because this involved reconfiguration, including a consultation on maternity and A&E service closures. The politics associated with service change are often very hard to navigate, especially with boroughs, councillors and officers'

accountability for delivering change across eight boroughs, with perceived winners and losers. We made some changes and were stymied in other areas.

We have also seen some boroughs' commitments to work more collaboratively change. A tri-borough arrangement in inner north west London partly split due to a change in the party of councillors after the local elections. That alters the commitment to certain work programmes and collaboration.

We engaged the public in much of the reconfiguration work on A&E, out-of-hospital and maternity services, but this was clinically led, with all the combined medical directors on stage with chief executives.

On the whole, this served us well, even if it wasn't always easy. You often deal with particular interest groups, but our central tenet was to develop changes actively with the public and other stakeholders in formulating the plans for change.

## What success would look like?

As we develop a more integrated approach, face-to-face care should not be the only delivery model in the future. I still think we will see a broad model of traditional A&Es and acute services existing, but maybe with one or two fewer sites.

It will be interesting to see if more specialist services consolidate further, like trauma and stroke services have done. I expect we will see more of those consolidations across fewer providers, but with an expectation of good networking arrangements across big urban environment like London.

What would be hugely beneficial for the population would be better networking of health and social care.

Longer term, on the provider side we could be looking at West Middlesex University Hospital moving away from being a traditional district general hospital with an emphasis on delivering emergency care. It might become much more of an integrated care hub with more enhanced primary care and mental health provision, better co-located and enabling a more integrated care offer.

That kind of change is more complex to try at Chelsea and Westminster Hospital, both physically in terms of land and estate, and because of the types of services we provide. The more peripheral hospital sites in our area have bigger physical estates, which may well lend themselves better to more integrated services and to teaching. On the more central London



***The politics associated with service change are often very hard to navigate, especially with boroughs, councillors and officers' accountability for delivering change across eight boroughs, with perceived winners and losers.***

sites, we may see more specialisation of services, perhaps with less emphasis on physical co-location to support integrated care in a more community-based setting.

In essence, if the integrated agenda works then services should be different for the local patient population in five to ten years' time. The long-term vision has enhanced elements of provision in community settings: more enhanced care in people's homes and other community settings, as well as technology enhancements that will support the delivery of more virtual care.



***National bodies still see and regulate us as sovereign organisations on performance, which unintentionally undermines working across boundaries.***



## JAGTAR SINGH OBE

Chair  
COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST

41



Jagtar has over 28 years' strategic leadership experience in senior public service and national roles, including 20 years in the fire and rescue service and 18 years in non-executive roles in the ambulance service and hospital foundations. In 2015, Jagtar was named by the HSJ as one of the top BME influencers in the NHS.

When STPs were first announced, as a non-vanguard area we saw this as an opportunity and were quick off the mark to take up the challenge. We soon realised it would be a much slower process for our STP, as opposed to those geographical areas that already had more developed partnerships under the new models' 'vanguard' banner.

### Working as a system

When I was appointed chair, there were limited local system meetings. With our local CCG chair, I set up more regular chairs' meetings to discuss strategic issues informally and to start to build trust, essential in all partnerships of course. We already had good health and wellbeing board engagement in the area and we also had a good memorandum of understanding between Warwickshire and Coventry.

Under the umbrella of the STP we have built on these 'building blocks' and have a good working STP structure, involving chief executives, medical directors and other directors. I am also fortunate in that one of my trust's non-executive directors is a pro vice-chancellor at Coventry University and also chairs the clinical design authority of the STP. Along with that additional level of involvement in the clinical design, it also helps inform the board on progress with the STP. As a board, we have a good collective grip on our STP, but we would like to make faster progress that is well understood by all in the STP and by NHS Improvement.

Our strategy is one of partnership and collaboration with anyone where we can see a clear benefit for patients and staff. This enables my chief executive and board directors to work well in pushing the STP agenda.

The STP has enabled us to develop and improve in a number of key areas, for example in implementing a new model of stroke care, and has helped ensure mental health is higher on the partnership agenda. It has helped secure additional mental health staff into A&E to support patients who need our care at that level, and we are working with our acute, CCG and local authority partners to build a better out of hospital offer in the community, provide care closer to home and improve discharge rates at the acute hospitals. In short, the STP will lead to better joint working overall and improved patient outcomes.

### Building trust and listening

We have to build the trust, create the narrative and business case for staff and stakeholders, get community engagement right, listen to what the public say and meet their challenges.

I believe talking about ACOs and ICSs is a big distraction for the public, and only helps to further confuse the people we serve. The discussion should be around how we work in partnership, not about structures.

We should convince the public about the benefits of working in partnership and collaboration and we need to avoid driving the discussion around structures.

The key thing is building trust between leaders, the community and politicians. We receive constant questions about our motivations for proposed changes and both STPs and accountable care have become a poor brand in the eyes of the media. We need a clear narrative about why this work is happening. In my view, STPs should deliver four things:

- 1 Better outcomes for patients:** A move to place-based care should be about improving outcomes for patients and must of course involve full consultation with staff and the public. There are also opportunities to improve the practical support that partners offer each other, for instance improving clinician-to-clinician communications or exploring how a community and mental health trust can support an A&E under pressure.
- 2 Better workforce planning, recruitment, retention and culture:** Workforce planning on an individual organisational basis risks wasting good resources. It needs system-wide work with all stakeholders and, in particular, the local universities to plan for and train the right future workforce. We should benchmark better early warning retention rates.
- 3 Better shared use of resources:** Corporate and back office services such as human resources, medicines management, estates and IT can be shared more effectively. We have been working on this for many years and, supported by the Carter review, the STP provides a context to take this forward faster.
- 4 Making commissioning more consistent:** As a former fire officer, I cannot see why the NHS has a competitive commissioning model. If we reduce that commissioning waste, we can build better services and pathways, and STPs will have more success in achieving the *Five year forward view's* integration agenda

*The STP has enabled us to develop and improve in a number of key areas, for example in implementing a new model of stroke care, and has helped ensure mental health is higher on the partnership agenda.*

## Enablers of collaboration

What gets partners on board to work as a collective? The biggest driver is often finance. While that is important, in my view it should be patient outcomes. We must make the best use of our resources for delivering more services and drive better outcomes for all our patients. Through the STP, we can achieve these joint objectives of greater efficiency and better outcomes

As a public service, and to be true to our values and the NHS constitution, we have to take the public and community with us on the STP journey. This may mean changing some things more slowly, for example NHS



***We may get some economies of scale by having fewer boards and fewer single organisations, but if providers become too big then boards may struggle to assure themselves about the quality of care they provide as it will be too far from the decision making.***

structures. Crucially, we also need the support of our local politicians, MPs and local councillors, elected as they are to be the voice of the public.

As far as structures go, whether you have one, two or three NHS provider trusts or boards doesn't matter – improving patient outcomes is the aim and that can be achieved through integrated care partnerships, just as well as through structural integration. We should also be very clear that there are potential risks in consolidating too far or too quickly – we may get some economies of scale by having fewer boards and fewer single organisations but if providers become too big then boards may struggle to assure themselves about the quality of care they provide as it will be too far from the decision making.

Short-term contracts also form a barrier and I would welcome longer commissioned contracts over five and ten years. In the fire service, I knew my budget for the following year to 1-2%. In the NHS, providers can lose anywhere up to a third of revenue if losing a major contract – how can we plan for serious investment in estates, IT and workforce if we can lose big contracts in that way?

My learning from our experience of working within the STP to date has been:

- be clear on your decision-making structure
- be clear on the narrative to staff and the public
- have measurable short, medium and long-term goals and keep your focus on them
- if there is a leadership issue in the STP, consider the benefits an independent chair of the STP might bring
- partnership and collaboration are not totally free – ensure you allocate resources to make it work
- STPs should ask if we have the right level of trust in the room to be open and candid with each other?

## What will the future look like?

If STPs and ICSs work, we may see many fewer trusts, where that is appropriate. Hopefully, the flow of patients between different types of trusts will be smoother and patient records will flow.

The key point I keep coming back to is that our aim, through working collaboratively, is to support better health outcomes and reduce health inequalities within systems and between geographical areas – achieving better outcomes per patient per pound.

## TIM GOODSON

Chief Officer DORSET CCG  
Lead DORSET STP/ICS

44



Prior to his current role, for nine years Tim was the director of finance at three primary care trusts. He originally joined the NHS as an internal auditor following his initial accountancy training with chartered accountancy practices in the private sector. Tim later moved into the NHS provider sector with Dorset Community NHS Trust.

Our challenges as a health system are the same as everyone else's. Workforce is our top priority – we have a very high elderly population (well over national benchmarks) and we're under national benchmarks on the available workforce. Our providers have been recruiting from Portugal, Spain, Ireland, Italy, the Philippines and Dubai.

Finances are another major challenge – we're doing better than most areas, but our providers have been in overall deficit. We're totally reliant on our providers earning the sustainability and transformation fund to keep things manageable money-wise.

With regards to quality, until recently all our providers were CQC-rated as 'require improvement'. Three of them have recently been rated 'good', which is very positive news.

### System thinking

Coming together as a health system has been rewarding. It's pleasing to see organisations within our health economy acknowledge that they can't solve these problems on their own. That approach has been tried and tested and it leads to a degree of in-fighting.

Dorset's 'can we do this together?' mindset and approach predates by some time the advent of STPs and the move to ICSs.

By bringing all the local players together, as the CCG we can give a strong steer. We have collectively set our system up as an ICS.

Our priorities are:

- prevention at scale: helping people to stay healthy and avoid getting unwell
- integrated community services: supporting individuals who are unwell by providing high-quality care at home and in community settings
- one acute network: helping those who need the most specialist health and care support through a single acute care system for Dorset
- leading and working differently: giving the health and care workforce the skills and expertise needed to deliver new models of care in an integrated system
- digitally-enabled Dorset: increasing the use of technology in the health and care system to support new approaches to service delivery.

### Finance

Our work as a system is most advanced in tackling the financial challenge. We agreed to work as one finance system and stop focusing on payment by results (PbR). Our aim is to get each organisation to hit its own control total, but more importantly to ensure that we can hit our overall system control total, combining all providers and the commissioner.

We monitor the Dorset system, coming together as group of finance directors and chief executives. The approach we take is 'this is Dorset's system wide finance number: are we delivering individually and collectively and is there more we can do to help across the system?'

It took a lot of background work to get to a system-wide approach to the finances. We agreed in 2017/18 we would have flat cash across providers, then a 1% increase for 2019/20.

At the end of 2017/18 we moved money between organisations to hit all the individual control totals, we wanted to get everyone over the line. This would never have happened without our journey to see ourselves as a system. To work as one on finance is a huge step to take.

## Workforce

We're now trying to repeat that across the workforce, and are implementing a 'Dorset passport' approach, so that staff can move freely between any organisation. Our recruitment campaigns will start promoting working in the NHS in Dorset, as opposed to individual organisations. We recruit to the county, and then agree with staff where they will work.

We hope this will allow for easier change in the workforce, so a career is not just in an acute setting, for example, but mixed with working in the community – and clearly not so organisation-specific.



***At the end of 17/18 we moved money between organisations to hit all the individual control totals, we wanted to get everyone over the line and hit their numbers. This would never have happened without our journey to see ourselves as a system.***

## Legislative tensions

Ours is an all-foundation-trust provider economy, and there are all-foundation-trust communities around us on all our borders. This is important because of the tensions with 2012 and 2003 legislation.

The whole NHS is not set up to work as a system. Every foundation trust has its own board, governors and members. Regulators assess providers as individual organisations. We try to communicate that we understand why they do this as a regulator, but a person will not just receive services from one provider organisation. Their main contact will be with their local primary and community services, be it their GP, pharmacists or community teams. If they have acute care, it'll be for a short spell and then they go back into the community.

As a system, we're trying to create that 'whole life story', not just focus on one organisation's bit. Our providers are keen to be involved in that conversation for the benefit of the whole system and it must be better for individual patients.

We are aware this goes against some of the legislation and it's taken quite a brave move from NHS England and NHS Improvement to give us permission to be flexible and to encourage our system approach with flexibility on PbR and system-wide performance targets. Their view was that if we all agreed to work differently (which we did), we didn't need to hide behind the 2012 Act, as there are enough flexibilities to work as a system and still meet individual requirements.

At some point, this work will require some legislative changes to progress. Our ICS coalition functions on the basis of providers, commissioners and the local authority all agreeing to work together.

## Local authority and public health perspectives

We have three top tier local authorities in Dorset. When public health transferred to them after the 2012 Act, we managed to keep the staff who moved over from the primary care trust together as one team hosted by one local authority, but working out of all three. That was helpful to keep the consistency and critical mass for constant public health messages.

Those staff act as NHS-local authority 'go-betweens' as they understand both sides' issues, and that's been a useful conduit for conversations. Our local authorities are keen to look at the wider determinants of health through the health and wellbeing boards – something that has a really strong emphasis in our STP.

We want to focus more on employment, housing, open spaces, education and transport. That is the foundation for our people's future health. Our STP restarted local authority engagement, as things had become quite clinically driven. Developing the STP reignited an opportunity to collaborate more effectively with our local authorities and public health. The police and fire service also sit on our HWB. We're doing as much as we can to get that population view.

We now work more closely with the local authorities than we have done for a number of years. The local authority is core to our ICS leadership meetings. We meet with portfolio holders and council leaders and it's important to get their political support and buy-in. It does now feel that this is a Dorset system.

## Public engagement and social media

We started with a public opinion survey with our local authorities across Dorset – 'The Big Ask' – to find out what they thought of services. That was five years ago and set the landscape.

Then came our clinical service review, predominantly focused on how best to organise health services. Throughout this review, we held numerous public engagement events and publications supported


by traditional media and social media. We wanted this to be very open and transparent and we put everything online (recorded events and plans) at [dorsetsvision.nhs.uk](http://dorsetsvision.nhs.uk).

The formal consultation ended in February 2017, and while it ran, awareness about the NHS review and proposals for changes to acute, community and mental health services was very high in Dorset. We dealt with petitions, marches and demonstrations, as our plans were fairly bold. Even now, we are awaiting the judgement to a judicial review which was heard in July.

Much of the commentary about accountable/integrated care seems to focus on a fear that it means bringing in a health insurance system or is a prelude to privatisation. This fear is still prevalent on social media, especially Facebook.

Equally, we used social media to promote our actual plans which was a huge opportunity to share these with people who would not have seen them previously. Even though we did numerous drop-in and pop up events and printed hard copies, the real public momentum was through social media.

We also used paid-for advertising to take people to our website and over 50,000 people clicked through this link. It was a really cost-effective way to target the demographic that we wanted to reach, and meant that they looked at our proposals. Social media is useful, but its power cuts both ways – there's a lot of misinformation posted as well.



*As a system, we're trying to create that 'whole life story', not just focus on one organisation's bit. Our providers are very up for that conversation for the benefit of the whole system, and it must be better for individual patients.*



## ANDY BURNHAM

Mayor  
GREATER MANCHESTER COMBINED AUTHORITY

48



Before being elected mayor of Greater Manchester, Andy was MP for Leigh from 2001. In government, Andy has held ministerial positions at the Home Office, Department of Health and the Treasury. In 2008 he became secretary of state for culture, media and sport, before returning to health as secretary of state in 2009.

My vision for health and social care in Greater Manchester is a whole person service able to deal with the full range of an individual's physical, mental, emotional and social needs. This should not just be about our offer for older people, it's an approach which must begin at the start of life.

It's a social model rather than a medical approach. Let's start with the person and prevention, before we consider treatment. And we can't deliver that overnight, it's a journey we're on in Greater Manchester. That said, the benefits of devolution for the health and care system in Greater Manchester are already emerging, even though it's early days. Things are possible here that just are not possible elsewhere.

### One conversation

In Greater Manchester it is possible to have one conversation with all the players in the same room around health and social care – a chance to get a single vision shared by everyone and to start to pull in the same direction. It remains a constant struggle to reconcile local and national priorities, but it is possible to align national policy makers' decisions and timeframes with our devolution ('devo') deal.

The skill of Jon Rouse (chief officer, Greater Manchester Health and Social Care Partnership) in leading Greater Manchester in this 'shared conversation' is pivotal in offering us a greater ability to make our public services more joined up than anywhere else.

### A Marmot city

As mayor, school readiness is a key priority for me (based on the findings of the Marmot report<sup>1</sup> I received as health secretary). Its conclusions were that if we help people leave formal education with a sense of hope and purpose, we've done more than anything else to support them with lifelong good health.

You have to get this right at the very beginning, which is why we're trying to implement Marmot's recommendations here in Greater Manchester. If we can get the health and care system, and wider public services behind the drive to increase readiness for school, the social benefits will soon show.

### Exceptionalism

Last winter we took a different view on the national instruction to cancel elective work. We thought our system was performing slightly better

1 Michael Marmot, *Fair Society Healthy Lives* (The Marmot Review), February 2010. Available at: <http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review> [Accessed 12 June 2018]



than others, so we didn't cancel all elective operations. It was the right decision for us.

Another example of our collaborative, whole person approach is our drive on homelessness and rough sleeping, levels of which have risen higher everywhere. I do walk-arounds in the city centre and heard homeless people were struggling to get to see a GP, while being discharged straight from acute care to the streets, with a lack of mental health outreach.

Jon Rouse and the team got to work and we now have a policy that all people can register with a GP even if they're of no fixed abode – 500 homeless people have already done so. We also have a new policy that means people cannot be discharged early from an acute setting to no fixed abode.


### Different conversations, in different ways

These are practical illustrations of how we're having different conversations about different priorities, working together differently and delivering different results. These are the benefits of devolution.

By contributing to more joined up preventative work, in the end the NHS in Greater Manchester benefits. I think that principle should be extended: every part of England should have same ability to have one conversation.

### Integrated care and place based working

I have a high degree of confidence in the work being led to develop and implement the integrated care models here. As shadow health secretary a few years ago, I was involved with the local health and care leaders setting out on this journey.



***If we help people leave formal education with a sense of hope and purpose, we've done more than anything else to support them with lifelong good health.***

I had conversations with Sir David Dalton (chief executive, Salford Royal NHS Foundation Trust) and Sir Michael Deegan (chief executive, Manchester University NHS Foundation Trust), who, with their community providers and commissioners, have been on this path for a while. You can look back to 2009 when I was health secretary, and in another speech I gave in 2013, that was the first time I referred to the concept of 'whole person care', meaning the full integration of social care and healthcare wrapped around an individual person's needs and goals.

Back then I was saying that just as we have a National Health Service, we need a 'National Care Service', but with devolution in Greater Manchester we've actually moved beyond that to develop one integrated service. At that

time, I was discussing integration as a national policy approach and working with colleagues here locally to implement it. Events followed our lead, and collaborative working has developed in the right way for us. Privatisation is not on the agenda here, as there is no local support for it.

## Optimising the money in a fragmented world

In my old speeches, I used the phrase 'integrated care organisation'. I like the idea of more accountability in the system, but we don't use the term accountable care organisation (ACO). We should probably talk about local care organisations in the future, as we already do in Greater Manchester.

We need a structure overseeing the care journey of individuals from home to hospital, giving a single organisation responsibility for oversight and organisation of the patient journey. That could be a single provider such as a local care organisation working with an alliance of GPs and the voluntary sector or a local care alliance. The aim must be to optimise the patient journey.

I still believe we need legislative reform to enable integrated working to reach the next level. We can change things so far through voluntary, collaborative agreements between local health and care organisations but it will not solve everything. Eventually parliament must fix the legislation.

I particularly advocate financial reform. Financial incentives in the system as it stands don't support preventative forms of care. Our system underfunds adult social care and overpays hospitals for episodes of care, so funding inevitably gets sucked into acute providers. We need to adapt NHS and social care finances to support more preventative, person-centred care including approaches like the 'year of care' – a single payment to a lead local organisation, with incentives for the system to support people preventatively in their own home.

In Greater Manchester we are bringing money together now into single pots in each locality. If we see the total investment in health and care within a local area or local system as one consolidated budget – for social, primary and acute care – we can optimise how funding is deployed and deliver better care.

We've also got to pay differently for social care, and get it aligned with the NHS principle: everyone must contribute in some way so that everyone has protection, and is 'covered'. Until the two systems fully speak the same language, we're integrating talk rather than reality

## Prevention

I want to see social prescribing as a first port of call, not a fringe add-on. And the NHS's first thought should often be to refer people for exercise, counselling, talking therapy, and debt advice.

Debt, poverty, housing, relationships and work are often the root causes of poor health in Greater Manchester. We must get to root causes more successfully and find solutions.

Much more becomes possible with the NHS in the room. Other places trying devolution will want to develop alignments between the NHS and their police and crime commissioner. We have that critical mass of aligned local leadership within Greater Manchester. As an example, we are developing joint commissioning approaches across health and justice on liaison and diversion. In addition to helping to integrate health and care services, NHS organisations have a key role to play in supporting a more preventative, longer term approach to wellbeing and in paving the way for wider public service reform.



***We need a structure overseeing the care journey of individuals from home to hospital, giving a single organisation responsibility for oversight and organisation of the patient journey.***

However, where our approach sometimes falls down is also interesting. We are pioneering place-based working – the Greater Manchester community involves the council, NHS, social care, and the police, but it sometimes falls down at involving the Department for Work and Pensions (DWP), often despite the best endeavours of Jobcentre Plus locally.

We work much more successfully with the same families and develop solutions together for their challenges. But when we have to phone the DWP, especially around benefits, that's still the old system and we're in a queue like anyone else. We do have a modest DWP budget devolved in the health arena, for a work and health programme called Working Well. For the past four years we've been achieving better outcomes than the national work programme managed (nationally the average percentage of similar people achieving work outcomes via the

programme was 10-11%, here, it's 22%) because our approach is more supportive, providing individuals with a key worker and access to talking therapies and broader support. However, we could go much further if the DWP would have the same relationship with us as the NHS does. We have built some good foundations but in a partnership together we could do much more.

The same could be true of education – the more public services we add in, the more we can develop this whole-person approach. It's not about just care, but about life. The enabler in the current Greater Manchester system is health, the barrier is lack of devolution of DWP and education.

We're addressing school readiness through volunteerism at present, but we could do a lot more big stuff if we were empowered to.

## The Westminster gap and the future

Public engagement in the devolution process in Manchester has been important. I came out of Westminster with a really clear sense I would be making a big mistake if I came here replicating the old Westminster/national government way of doing things through yet another additional tier.

This is a big opportunity to bring power closer to people through devolution, get people to take the power than hand it to them.

We're working together to try to build the new politics here. All governments, including Labour-led administrations, have tried to run the country through London-centric centralism.

But look at where we are now as a divided country. Had Westminster looked after all local places equally, perhaps we would have avoided the outcome of the Brexit referendum by ensuring resentment did not build up in those places which were less well looked after.

For me, devolution is the answer – the world is fragmenting, countries and cities are moving at different paces. The idea of the nation moving at one pace might have gone out with the 20th century.

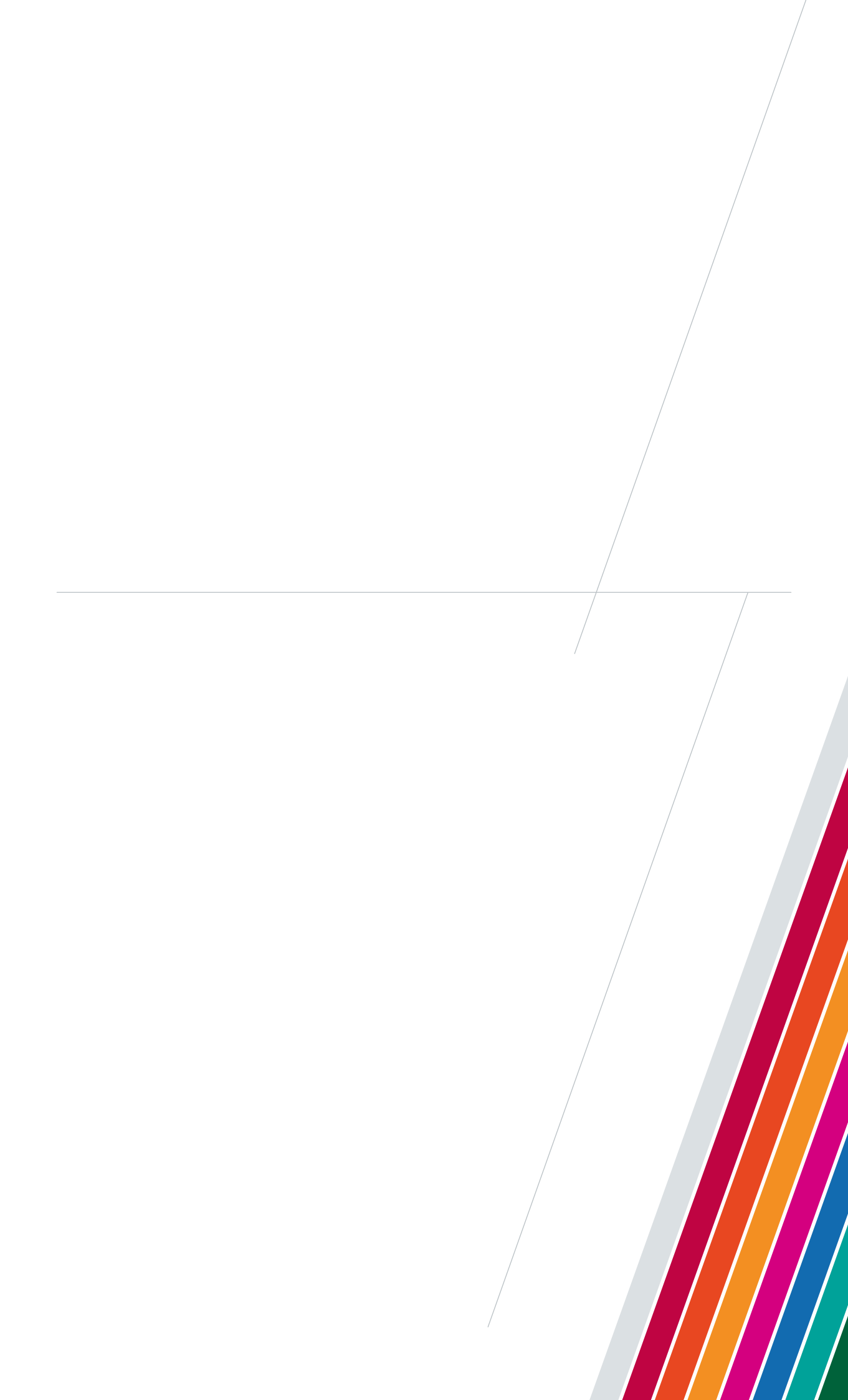
Westminster needs to be enabling, set a broad policy framework and let people do what works together locally. Government should support more localism. We need to go back to the grass roots for rejuvenation. That's where I am on my political journey: I'm proud to be a part here in Greater Manchester, in a collective rather than an individual, endeavour.




***In addition to helping to integrate health and care services, NHS organisations have a key role to play in supporting a more preventative, longer term approach to wellbeing and in paving the way for wider public service reform.***









**NHS Providers** is the membership organisation and trade association for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in membership, collectively accounting for £84bn of annual expenditure and employing more than one million staff.

Read the report online

[nhsproviders.org/provider-voices-integrated-care](https://nhsproviders.org/provider-voices-integrated-care)

Join in the conversation

**#integratedcare**



One Birdcage Walk, London SW1H 9JJ  
020 7304 6977

[enquiries@nhsproviders.org](mailto:enquiries@nhsproviders.org)

[www.nhsproviders.org](https://www.nhsproviders.org)

[@NHSProviders](https://twitter.com/NHSProviders)

© Foundation Trust Network 2018

NHS Providers is the operating name of the Foundation Trust Network

Registered charity 1140900

Registered in England & Wales as company 7525114

Registered Office

One Birdcage Walk, London SW1H 9JJ