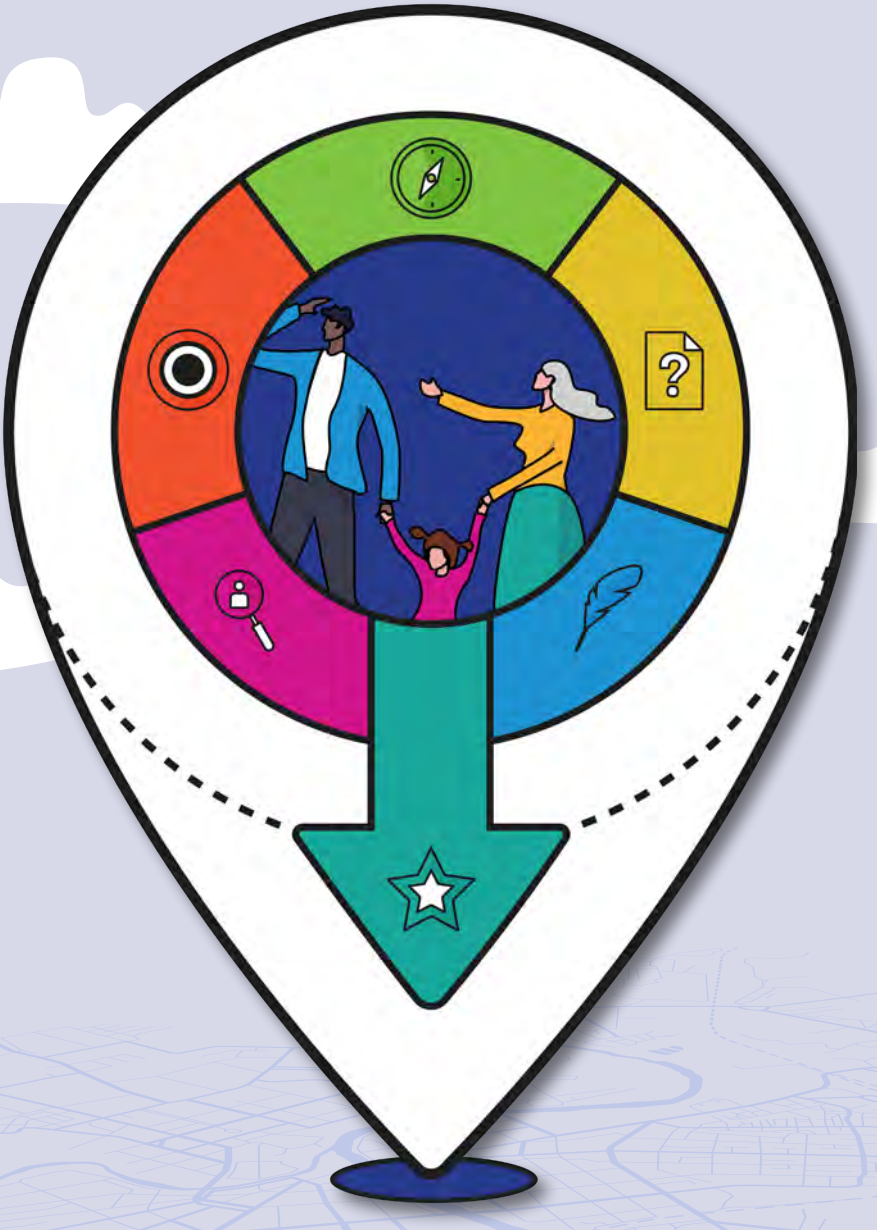
NEWTON

NHS Providers



Integration at place

From ambition to delivery

A practical toolkit to help place-based partnerships make integrated health and care a reality

www.integrationatplace.org

ABOUT NHS PROVIDERS

NHS Providers is the membership organisation 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 England in voluntary membership, collectively accounting for £104bn of annual expenditure and employing 1.2 million staff.

Website: **www.nhsproviders.org**

Twitter: **@NHSProviders**

Contact: **Leo.Ewbank@nhsproviders.org**

ABOUT NEWTON

Newton support health organisations and health and social care systems to redesign ways of working and implement measurable and sustainable change which is better for people, better for staff and delivers real financial benefit. They are specialists in tackling highly complex challenges, by designing and implementing the operational, digital and people-centred change that needs to happen to solve them. Newton work side by side with their clients, to bring insights which drive change, working together to design, implement and sustain lasting improvement. Their clients value them for their ability to embed sustainable change by working from the ground up - uncovering the root causes of the trickiest problems, supporting leadership to act on this information and working as part of their frontline teams to deliver real change.

Newton have a strong track record in doing this across whole health and care systems, helping system leaders to align their vision and strategy and translating that into an operational blueprint which they then co-design and deliver to fit the local situation. They put 100% of their fixed implementation fee at risk against achieving measurable results.

Website: **www.newtoneurope.com**

Contact: **david.mcmullan@newtoneurope.com**

Contents

Introduction

THE NATIONAL CONTEXT

Integration of health and care has been at the heart of local and national conversations across the sector for decades. Delivering better care that works seamlessly across all the services that an individual might need - hospitals, primary care, community providers, mental health services, ambulance, social care, along with wider partners such as the voluntary sector – is a central ambition for national policy makers and local practitioners alike.

Recent national policy

- Health and Care Act 2022 placing integrated care systems (ICSs) on a statutory footing from July 2022
- NHS England (NHSE) policy setting out aims of ICSs with place-based partnerships as their foundation
- Joining up care for people, places and populations: integration white paper setting out structural direction for place arrangements (2022)
- People at the Heart of Care: adult social care reform white paper (2021)

The Health and Care Act 2022 provides a new legislative framework to promote collaboration. Now, after years of development, ICSs are on a statutory footing. While key strategic decisions will be taken at a system level, and provider collaboratives are driving delivery and improvements for services best delivered at scale, there is also a national policy expectation that systems will work through sub-system geographies.

These places will lead and deliver much of the operational detail to **make integration a reality** through place-based partnerships. The integration white paper (February 2022) aims to further accelerate integration at place, with a focus on leadership, governance, budget alignment, and workforce at the local level.

MAKING INTEGRATION A REALITY: FROM AMBITION TO DELIVERY

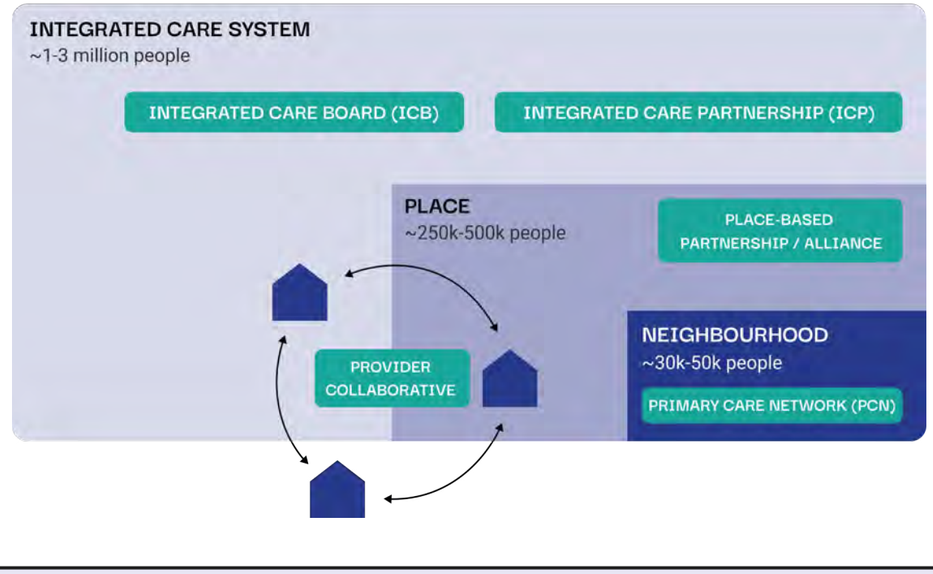
The journey from ambition to delivery is one of the greatest current challenges facing policymakers, system leaders, and frontline teams. The complexity of organisations and of the geographical, operational, and political landscape in which they sit, has made integration far from straightforward.

The operational detail to integrate services must be developed locally. As the complexities and needs of local populations differ in each system there is no standard, 'one size fits all' solution. Much positive work has been done and many systems are developing innovative ways to deliver better, more joined up care, but there is still progress to be made.

As a means of focusing efforts and ensuring that work takes place at a scale where integration can have the greatest impact on service delivery, the importance of place has been strongly advocated in national policy. In many ICSs, the concept of place provides a tangible and practical scale for staff and leaders to design new services and models of care, enabling them to work together to deliver better outcomes for the local population – the very essence of integration.

THE INTEGRATION LANDSCAPE

Different vehicles for collaboration:



AIM OF THIS PROGRAMME

Throughout the policy changes of the last few years and particularly in the formalisation of ICSs in July 2022, much of the focus has been on issues of organisational structure. However, as important as this is, the drive towards integration is about delivering better care for people. Integration of systems on paper - but business as usual in terms of how things work - is not the aim.

The fundamental challenge for place-based partnerships is to ensure the delivery of better services, better care for people, and measurably improved outcomes. The process is one of reimagining and redesigning service delivery. In a complex organisational landscape this is a challenging ask. However, set against the backdrop of (among others) extreme workforce pressure and recovery from the pandemic, the challenge is even greater.

Engagement with individuals involved in the design and delivery of integrated care at a local level has shown that there is a genuine determination to mobilise these new partnerships and to move beyond ambition, through to delivery of improved outcomes. There is no shortage of suggested models of integrated care and frameworks for transformation to support integration, including at place. **There is less support available, however, on how to deliver integration on the ground, in practical, operational detail.**

The aim of this work is therefore to provide a **practical toolkit** which draws together some critical components of an outcomes-driven approach to change; shares local examples of integrated models of care; and articulates the reality of the operational frontline, complete with its current pressures and challenges. The toolkit is designed to stimulate reflection on current work and future plans, and to help leaders working at place to make progress in their unique contexts.

METHODOLOGY

Developing this toolkit has been a collaborative programme of work between NHS Providers and Newton, drawing heavily on the insights of NHS Providers' members, Newton's clients, and beyond.

In total, over 200 representatives from across the health and care sector have been engaged. In a range of capacities, these individuals have been involved in leading, designing, and delivering integrated care at place. The individuals were selected to ensure that a range of experience from across the country has been represented. This toolkit, an output of the joint programme of work, aims to reflect some of the breadth of views and insights colleagues have shared.

A number of systems and local partnerships have participated as 'reference sites', exploring and sharing their local experiences through workshops and interviews. This has typically led to a case study, which features in the toolkit. In a small number of case studies, patient stories are used. In these instances, names have been changed to protect confidentiality.

The programme has also drawn on a cross-sector steering group made up of senior NHS and local government leaders who have been instrumental in providing insight, constructive challenge and direction which has informed this toolkit.

Lastly, the toolkit has been created by drawing on Newton's insight and experience gained from working alongside trusts, local authorities, and place-based partnerships to reimagine and redesign public services to improve outcomes for people, ways of working for staff, and financial sustainability. It has also drawn on NHS Providers' experience of supporting trust boards to respond to national policy developments and the wider operational context.

NHS Providers and Newton would like to extend their thanks to all those involved in this programme of work for generously sharing their time, expertise, and support.

The experiences of the following systems and local partnerships contributed to shaping the toolkit:

- **Birmingham** (Birmingham and Solihull ICS)
- **Bolton** (Greater Manchester ICS)
- **Bradford District and Craven** (West Yorkshire ICS)
- **Harrogate (part of North Yorkshire)** (Humber and North Yorkshire ICS)
- **Lambeth** (South East London ICS)
- **Mid and South Essex Integrated Care System**
- **Northamptonshire Integrated Care System**
- **North West Surrey** (Surrey Heartlands ICS)

The approach

A core principle underpinning this toolkit – informed by reference sites' experiences – is that efforts to integrate care at place have been most successful where the changes measurably result in better care being delivered for people. Stakeholders engaged through this programme agreed that any work carried out to improve services - through place-based partnerships or otherwise - must result in a measurable improvement in outcomes for people and/or staff.

> *"This has to be about our population's health in five years' time, or this vehicle of integration has not been worth it."*
>
> Chief executive, Acute NHS Trust

THE TOOLKIT

The toolkit is designed to reflect this focus on outcomes. It is presented in **three sections** – some of the elements and steps required to start and focus on outcomes; some of the common barriers that leaders engaged through the programme felt needed to be overcome to make integration work successfully; and the crucial role of culture and leadership that underpins all of this.

Each section of the toolkit explores the range of challenges that those engaged through this programme said they have encountered. Sections then outline some of the ways in which these have been addressed in practical terms, followed by some case studies from reference sites.

The intention is that by describing experiences of making integration work on the ground, other systems can learn to pre-emptively address some of the issues that can slow or derail implementation.

More detail on the content of the three sections:

Section one - starting with outcomes

In practical terms, the toolkit explores the elements that need to be in place and the steps required to:

- start with outcomes
- ensure clarity on what must be achieved
- keep measurable outcomes at the heart of the design of place-based partnerships.

Section two – overcoming barriers to delivery

The systems involved shared some barriers they encountered delivering improved services with better outcomes and the process of making integration a reality. These are grouped into workforce pressures; competing demands and incentives; navigating governance and moving beyond a focus on structures; lack of joined up data and insight at place; and historical ways of working and behaviours.

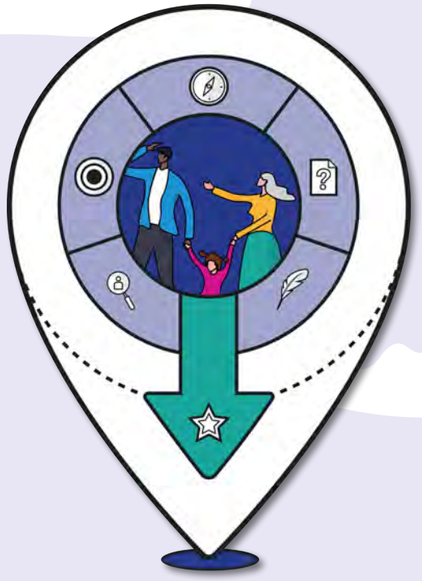
Section three - culture and leadership

Leadership skills and associated culture, behaviours, and norms are critical to the success of integration at place. In creating the toolkit, leaders reflected on the value of their shared commitment and ambition in overcoming the common barriers. They emphasised that the culture within organisations and on the frontline can make or break joint working and delivery of improved outcomes.

As described through the introduction, making integration a reality is highly complex and will not look the same in every place. While the toolkit is not designed to be comprehensive in its breadth or depth, individuals and systems engaged through this programme reflected that focussing on these areas can contribute to delivering better care and improved outcomes for people through new and optimised place-level services.

The approach is summarised here:

- Starting with outcomes
- Overcoming barriers to delivery
- Delivery of improved services
- Culture and leadership



AN 'INSIDE-OUT' APPROACH

Those engaged through this programme reflected that traditionally, systems often begin the process of integration at place by focusing on established solutions or by adopting new service models from elsewhere.

Measuring the outcomes is seen as a challenge to be undertaken once the system is running smoothly at a later stage. In taking this 'outside-in' approach and implementing an existing solution into a new system, the experience was of several complex obstacles or barriers to overcome, which then proved difficult to resolve.

As the barriers impede achievement of the anticipated benefits, leaders attempt to compensate and overcome them by driving the solution even harder. While this may work in the short-term, the symptom-fix will not be sustainable, since the root cause is the lack of a clear, outcomes-based ambition as the starting point.

Conversely, it was found that where place-based approaches are making progress and gaining momentum, partner organisations have all started with the measurable outcomes to be achieved. This generates a strength of alignment, culture, leadership approach and ways of working with which the system can tackle and overcome any barriers to change that do emerge.

Furthermore, it was found that the systems making most progress were regularly returning the focus to the outcomes. To apply continuous improvement in this context, these systems revisit the measurable outcomes on a regular basis, reviewing key measures as part of day-to-day delivery and governance. This allows service delivery to be iterated over time and supports a systematic approach to tackling or mitigating barriers.

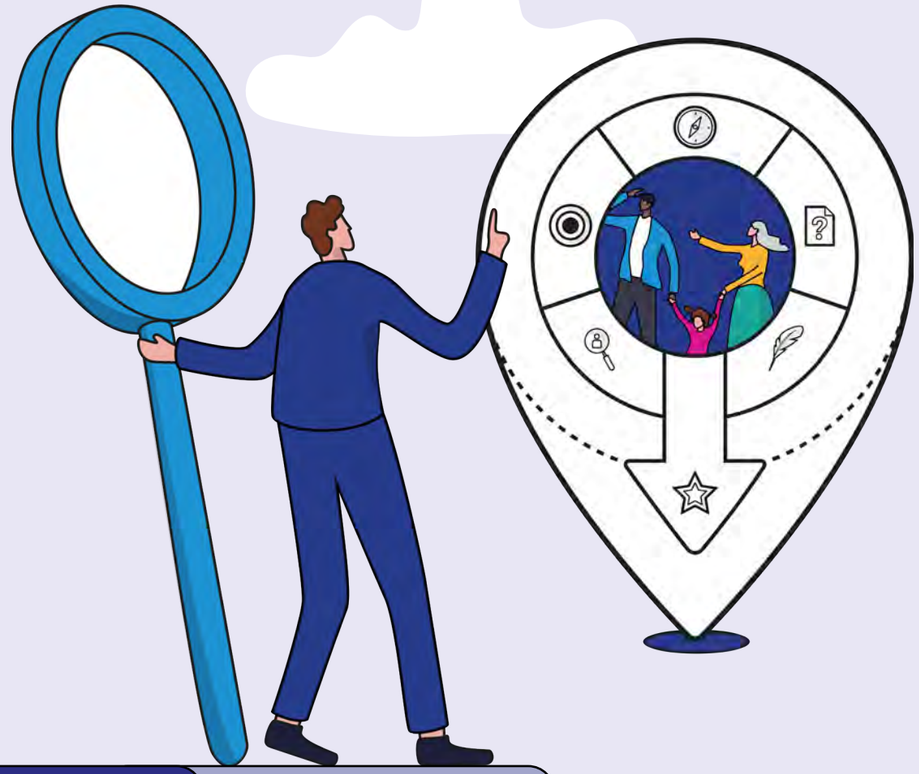
Starting with outcomes

Throughout the engagement for this programme, an 'inside-out', outcomes-based approach resonated strongly with local systems. Many leaders reflected that while prioritising outcomes is often talked about, in practice it is much more difficult to do. All too often change is initiated from the outside, with new processes and services being put in place because they provide a ready-made solution.

It was suggested that while many providers may have been implementing service changes, the crucial link to measurably improved care for people is sometimes lacking. There may well be positive intent with some target outcomes agreed.

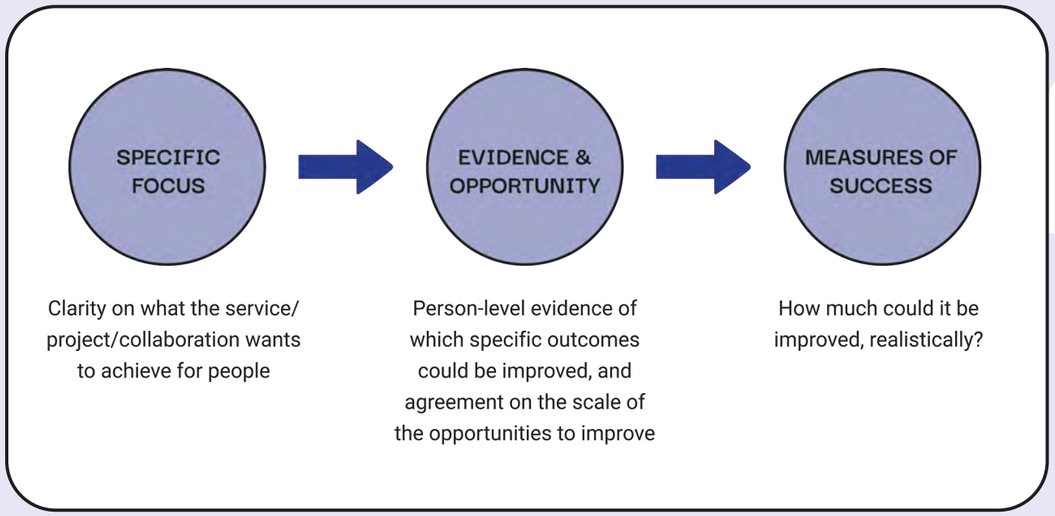
However, as work progresses, systems can lose focus on the specifics of outcomes. It was reported that a generic targeting of 'better outcomes' does not have the impact to drive the system to reach the level of improvement that could and should be achieved.

> *"We are too focused on inputs and not outcomes, and the real value of place."*
>
> Chief executive, Acute NHS Trust



WHAT DOES 'STARTING WITH OUTCOMES' MEAN?

There are some key steps to make sure systems are set up for success; in a complex environment it is important to establish whether these are in place across the system. Three critical elements were commonly found in systems which 'start with outcomes' and are explored in further detail here. Although they may seem straightforward, some systems observed how time pressures and the focus on the short-term had proved to be a distraction, preventing them from building the right foundations.



SPECIFIC FOCUS

Many systems engaged through this programme raised the issue that while the purpose of partnership working was being described at a high level, what needed to happen was agreement on a specific focus that will drive delivery.

Systems that 'start with outcomes' define the purpose of coming together with partners to work at place and are as specific as possible regarding what is to be achieved in terms of an outcome. Most place-based partnerships have an articulated vision informed by system and local priorities. There is sometimes a gap, however, between this vision and the practical delivery required.

The missing element is the identification of the specific improvement being targeted and a delivery plan to realise the benefits. Leaders of systems frequently mentioned that while they had thought that they had articulated a clear purpose at the beginning of their integration journey, they subsequently realised this had been pitched at too high a level or had simply comprised a series of **inputs** rather than the desired **outcomes**. As a result, leaders had encountered challenges when seeking to clarify and drive the operational changes to ensure better care would be delivered in practice.

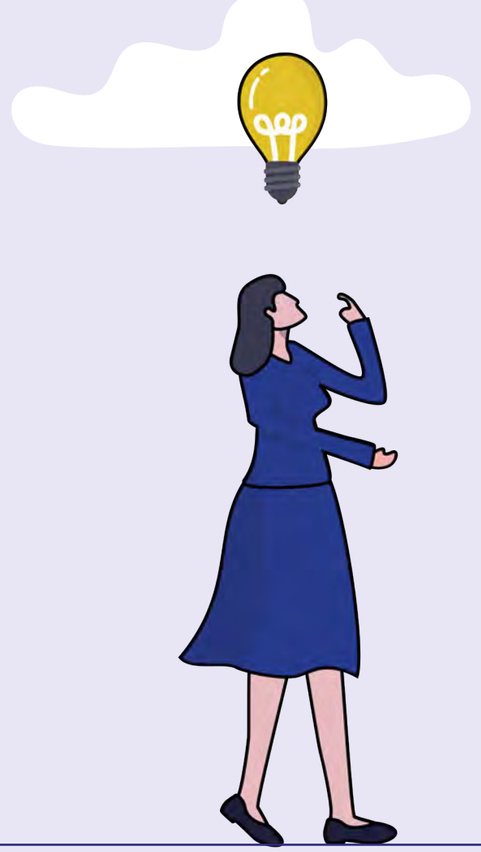
Experience shared through the programme, including from the reference sites, has shown that where systems or change initiatives have an input-based purpose such as "to set up this new service" or "to bring these teams together", there can be a similar lack of clarity. Equally, it can be particularly challenging to focus effort on the right place when the purpose is too generic – for example, having a purpose of "to improve outcomes" is unlikely to provide an appropriate level of focus to deliver improvements.

"There is a risk that everyone integrates, the new structures are described and put in place, but actually we're not really population focused. We might orientate around structures, but we won't be clear enough or specific enough on the purpose of doing it. We'd be better off squabbling but focusing."

Chief executive, Community NHS Trust

"Saying you want to make everyone healthier is not a purpose around which you can integrate."

Chief executive, Community Provider



In systems that 'start with outcomes' leaders agree the purpose from the outset – "this is why we are doing this". They are also specific on the detail of what outcomes are to be achieved for **people**. Their purpose might describe a future achievement, perhaps linked to the population being served. It can be short and in straightforward language such as:

- To ensure everyone receives the same high-quality care and support regardless of place, time, or person.
- To reduce the overall cost of long-term care in the system to ensure long-term financial stability and investment in new priorities.
- To reduce the number of people being admitted to hospital when that isn't the best setting to support their care.
- To support people to be as independent as possible in the community.

It may be a combination of multiple indicators, including the above, or embrace many other elements.

CASE STUDY

The health and social care organisations of Birmingham acknowledged it was vital to transform intermediate care for older people across the City, and doing so would mean some colleagues and services integrating in order to deliver improved outcomes for citizens. The system leaders worked to align behind a single vision for the future of these services driven by clear outcomes not services or structure.

For example, outcomes such as:

- **Reducing inappropriate admissions to acute hospitals**
- **Reducing delays leaving hospital**
- **Reducing discharges to inappropriate settings from hospital**
- **Increasing the proportion of people receiving either bed or home-based support to achieve a greater level of independence.**

These outcomes allowed system partners to remain focused on what transformation needed to achieve, and spend less time in conversation about individual organisations and services, which greatly improved and increased decision-making even on what would have previously been sensitive cross-organisational topics.

EVIDENCE AND OPPORTUNITY

Many local teams engaged through this programme shared challenges in gathering reliable and consistent evidence of what their current performance is, and what it could be. Even for systems with good quality data and reporting, it was agreed that it is rare to find existing data that illustrates the gap between current and potential performance, that sheds light on why that gap exists.

Systems that 'start with outcomes' establish the evidence of what could be better. Knowing that there is a possible improvement to be made, and how great that improvement might be, allows them to prioritise resources in the right place. This ensures that partnership working for any given pathway or service has a measurable and positive impact for people. Ideally, the evidence is independent of organisation and service; an objective truth, backed up by data that everyone believes in. This provides an evidence-based starting point for identifying the issues and processes that need to change.

A strong evidence base brings many benefits, in particular:

- Confidence that an improvement can be made for people and the care they receive.
- Confidence that resources are being committed to where a real difference can be made.
- Ability to prioritise programmes based on the impacts they can generate.
- An objective truth that different organisations, leaders, and frontline staff, can share, refer to, and have as a starting point of common ground.
- An independent anchor to galvanise the purpose of the programme or change, unrelated to a particular organisation or agenda.
- An ability to quantify or estimate the expected future impact on people, operations, and finances.

CASE STUDY

In Birmingham, the health and care system agreed to establish an evidence base for transforming intermediate care services, thereby gaining an understanding of the scale of improvement that could be achieved with a single source of the truth that all partners recognised. To capture this, the system invested time and resource to complete:

- **A diagnostic exercise across five participating organisations, with the direct involvement of over 100 staff.**
- **Analysis of over 1 million lines of data from partners to analyse all service user journeys.**
- **A detailed multidisciplinary team review of 80 recent cases, focused on users' actual pathway and outcome, as well as identification of the ideal pathway and outcome.**
- **Data capture and analysis of over 500 people in beds, their next steps, and their outcomes.**

In this way a coherent set of evidence, centred around the outcomes was established, giving leaders and frontline teams a baseline to work from. Agreement from all the partners came, in part, as a result of the level of detail into the root cause of the challenges and barriers, as well as the opportunities, revealing insight well beyond what was readily available to the system.

This work allowed the system to agree, for example:

- **23% of the cohort reviewed that were admitted to hospital could have been cared for by other services, perhaps even at home.**
- **51% of the cohort experienced a delay leaving the hospital, i.e. spent longer than was necessary in a hospital bed.**
- **19% of the cohort when discharged from hospital did not achieve the best next step given their circumstances.**
- **36% of the cohort in a short-term bed could have gone on to achieve a more independent outcome.**
- **37% of the cohort could have achieved a more independent outcome without leaving their home.**

Quantitative analysis with qualitative individual stories was used as a powerful mechanism to bring confidence to the system on the extent and type of transformation ahead. Using the anonymised stories and real experiences also helped frontline teams relate to the evidence, and backed up what the data was saying – it gave the programme a time sensitive, tangible focus and united staff motivation to change.

Freda's Story

Freda is 87. She lives independently at home, and despite having poor hearing and deteriorating eyesight, she lives without support. After a fall at home, she was admitted to hospital for treatment.

After her treatment was complete, she was assessed for her ongoing care needs. The ward staff suggested to Freda and her family that they should consider looking at long-term care options for Freda, however the Occupational Therapist and Social Worker felt that she was coping well enough on the ward to be able to go home – she was up and about, taking herself to the toilet.

Freda's family could not be convinced of this. As she had now been in hospital for a while waiting for an intermediate bed, she was moved to another ward.

Here, Freda lost confidence due to a change in setting, lost mobility due to a lengthy hospital stay and became upset as she wanted to go home but didn't want to disagree with her family. The therapy team recognised this and tried again to get her home, but once again the family refused. Some weeks later, Freda was living in a residential home.

"The moment 'residential care home' was mentioned, was the moment the family decided that's where she's going. I tried as hard as I could to get her home, it's where she wanted to be."

Occupational Therapist

In its first eighteen months, the transformation achieved sustainable results including:

- 3,650 fewer older people admitted to hospitals, annually.
- Ensuring 26% of people who did go into hospital are now going straight home, avoiding long-term care.
- Reducing the time it takes for people ready to leave hospital from an average of 12 down to three days – the equivalent of 77,000 fewer days in a year.
- Increasing the levels of independence people achieve following a crisis as measured by the reduction of ongoing care each week by an average of six hours for every person.

Shared learnings on what to consider when building the evidence base

The following learnings have been drawn together based on the engagement and input into this programme of work:

- Capture more than simply whatever is happening right now. Capturing evidence of current performance as well as evidence of what could be achieved with improved performance and different ways of working, enables the case to be built for the opportunity to improve.
- Aim to triangulate using multiple sources of data and insight, recognising different data sources will have different resonance for different stakeholders. Avoid using any data source where people have historically questioned the accuracy.
- Use detailed case reviews with frontline staff to build a strong case for improvement. Capture data not available elsewhere from these cases, rigorously, to quantify what could be improved and the extent to which the improvements could be made.
- Population health data and other wider datasets can be used to identify inequalities, for example, where there is no reason outcomes should be different between or within places or systems. Benchmarking in this way provides a high-level indication of the size of the opportunity to improve, which can be backed up effectively with detailed, local evidence and case reviews.
- Some of the data or evidence required may not exist in a useful or accurate form. It is worth investing in collecting required evidence by new means, such as detailed case reviews, studies of frontline decisions to validate data, or new digital systems.

"When an individual story shows that we have let someone down as a system, and the big-data says we are doing the same for one in five people leaving hospital – that's when we have a compelling evidence base, and agreement that we must improve."

Transformation director, ICB

MEASURES OF SUCCESS

As well as starting with an outcome-based process, systems that 'start with outcomes' revisit these outcomes frequently and measure their impact. At the beginning of any programme to integrate at place, the outcome measures are tightly defined, based on the evidence base of what can be achieved, with frequent and rigorous reviews to ensure that the focus remains on achieving that level of improvement.

Many systems engaged through this programme described how they have found it challenging to agree a concise and meaningful set of key performance indicators (KPIs). As a result, this risks frontline design diverging from the initial ambitions.

In one of the systems interviewed, leaders shared how they initially set up a new integrated community service with 55 defined key performance indicators (KPIs). Many of these performance measures were already collected by individual organisations, but few of them were linked to the purpose of the new integrated service in terms of specific outcome improvements. COVID-19 derailed many of the measures, while 55 KPIs in total presented a challenge in terms of seeing clearly whether the change was having a positive impact on outcomes for people. After adapting over time, the partnership now measures specific outcomes where the work has had a real impact – for example, the number of people now supported at home that would have previously been in hospital. Leaders shared the difficulty and importance of getting the measures of success right.

> *"We measured KPIs, lots of them. We produced and reported them through the board. But I don't think we did enough on outcomes."*
>
> Director of strategy and integration, ICB

CASE STUDY

The Mid and South Essex health and care system delivered a transformation programme to improve outcomes for older adults. Their focus was particularly on admission avoidance, improved discharge pathways, and more effective intermediate care along with improved local collaboration for long-term support in the community.

OPERATIONAL KPIs:

Following the steps described above, a clear evidence-based opportunity was identified to improve outcomes for over 3,000 people every year. This was translated into a small set of tangible operational KPIs that could be monitored on a weekly basis, and the programme team was able to align efforts behind these measures. Targets were set, based on the evidence of what could be achieved. The partnership knew that if these targets were hit, the work had been a success and the integrated working would deliver improved outcomes.

8 operational KPIs defined:	Baseline	Target
ADMISSION AVOIDANCE		
Frailty avoided admissions per week		
UCRT avoided admissions per week		
COMMUNITY PATHWAYS		
Average number of delay days per Community hospital inpatient	**10.0**	**8.4**
DISCHARGE OUTCOMES		
Decrease acute discharges to beds Measure: Proportion of acute discharges to onward bedded care		
Decrease interim bed discharges to long-term beds Measure: Proportion of long-term placements after interim beds		
REABLEMENT		
Increased volume of finishers per week Measure: Number of reablement finishers each week	**113.2**	**137.1**
Increased reduction of care hours per week Measure: Average ongoing care hours reduced through reablement	**6.7**	**8.2**
SUPPORTING INDEPENDENCE		
Increased independent decisions Measure: Average weekly cost of care package following long-term decision	**£74**	**£60**

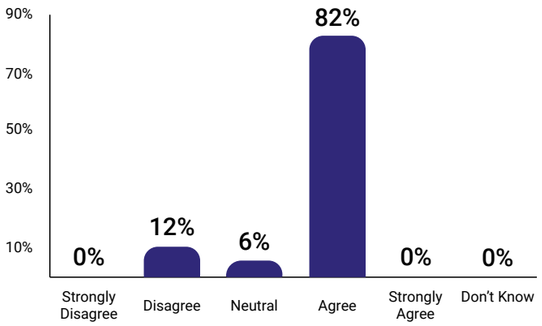
All KPIs tracked on a weekly basis for review by frontline teams, managers and leadership as required

LIVED EXPERIENCE:

Alongside programme delivery, the programme team set up a monthly capture of Lived Experience to make sure the changes were impacting adults positively and to enable identification of further improvements that could be made. This also provided a level of confidence that any unintended negative impacts for people could be identified and mitigated.

Example Lived Experience findings:

I am living as independently as possible



"I am very happy that what she has would be called 'independent living' as she is not in a care home. Home is the best place for her and to live independently."

Family Member's perspective

Also, 30% of participants reported that they are more independent than they used to be

STAFF BEHAVIOURS & FEEDBACK:

The programme team set up a rigorous method of capturing how well the new, integrated processes were working on the ground, along with how confident staff felt about the changes in their teams. This was designed with frontline staff, and created a simple way to track progress, highlight where more focus was required, and drive sustainability of the new ways of working. The team adopted a colour-coded, bronze/silver/gold approach to tracking new behaviours and ways of working, collecting monthly feedback from staff. This was key to tracking the sustainability of new behaviours alongside the operational KPIs.

FINANCIAL IMPACT:

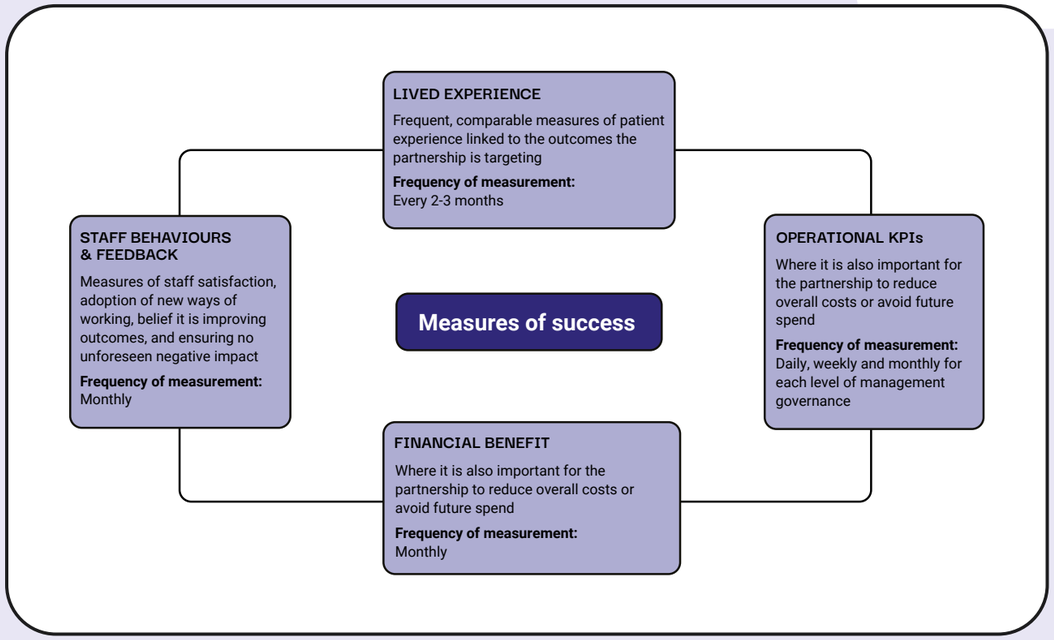
This programme involved a financial benefit alongside improved outcomes for people. The financial impact was calculated from the operational KPIs and it could be understood at a workstream level how operational changes impacted the financial position of each budget and for the system.

This combination of measurements across operational KPIs, staff and patient experience, and financial benefit gave confidence across partners in the direction and impact of the partnership working, and allowed resources to be focused in the areas requiring most improvement on a frequent basis. The information could be looked at holistically in programme and partnership governance forums to support decision-making and celebrate success.

Shared learnings on what to consider when developing measures of success

The following learnings have been drawn together based on the engagement and input into this programme of work.:

- A small number of well-defined KPIs tends to be most effective. Often, programmes have dozens of KPIs requiring much effort to gather and interpret, and which lack precision in illustrating how services are performing and the impact of the partnership working on outcomes.
- It may not be possible to track the ideal measure of success currently, but it is worth exploring investing in new ways to capture the data.
- Keep the operational KPIs as simple and tangible as possible – the more relatable they are to frontline teams, the more likely they will be understood and focused on day-to-day decision-making.
- KPIs that can be measured and acted upon at pace, sometimes on a weekly or daily basis depending on the service, will support faster iteration of ways of working. A six-month pilot with evaluation not undertaken until the six months is complete will give a slower model of progress and adaptation, less understanding, and most likely a reduced overall impact.
- As well as making sure the operational KPIs show that a desired level of improvement is being achieved, it can be helpful to incorporate the four areas of measurement below to measure the progress of place-based partnerships:



- Consider the connection back to the specific focus of the partnership working, and to the place vision. Meaningful measures of success should give confidence that if they improve, it will directly and positively impact outcomes in line with the specific focus, making progress towards the place vision.

ADDITIONAL CASE STUDIES

LOCAL EXAMPLE: POPULATION HEALTH MANAGEMENT

This system has delivered significant improvements to non-elective pathways over the last two years, with a focus on frailty intervention, urgent community response and effective discharge pathways, and intermediate care. The system is now starting to focus further upstream, and has agreed that preventative care, delivered at place and neighbourhood level, using Population Health Management (PHM) approaches, will be key to driving the best possible outcomes and preventing demand downstream.

The team has put measurable improvements to outcomes at the heart of its approach, in an area that is currently the subject of a great deal of attention, but without a clear link to how outcomes would be improved on the ground in practical terms.

It was found that 63% of A&E admissions were driven by 5% of the 65 and over population and preliminary modelling showed much of this could be predicted. In addition, early evidence showed that Advance Care Planning would provide a major opportunity to avoid admissions for people over 65. However, the system had no mechanism of identifying individuals who might need Advance Care Planning, and so the concept was paused.

The system then agreed to look again into building an evidence base and establishing the quantifiable opportunity for delivery. The specific focus was to understand:

- Does the prevention we undertake currently have an impact on outcomes?
- Could we predict the likelihood of escalation, to establish who will be likely to need what intervention, to avoid hospital admissions?

The 'proof of concept' phase has recently been completed, with encouraging results and the ability to quantify specific opportunities. By connecting multiple data sets across partners to create a joined-up view of an individual, combined with detailed frontline studies, a clear evidence base has been established. For the first time ever an evaluation of the impact that community delivered frailty interventions can have on patient and system outcomes has been established:

- Falls Risk Assessments – potential to reduce expected admission rate for applicable patients by 35%.
- Advanced Care Plans – an average of five days of inpatient stay saved for every patient in their last six months of life.
- Structured Medicine Reviews – potential to reduce expected admission rate for applicable patients by 25%.

A proof-of-concept machine learning model has been built, based on health history, conditions, demographic factors, and some wider determinants of health. This allows prediction of over seven out of every ten patients who will be admitted to an acute hospital in the next three months:

- The model has the potential to identify over 30,000 people per year who are most in need of targeted support across the system.
- The factors and combinations of factors that determine future risk or need have been evaluated.
- The model has the potential to address inequity of access to care. All people with a health history are considered.

Providing these interventions in a targeted way for all four pilot PCNs could deliver better preventative support for over 5,000 people per year, reducing demand on acute services and achieve over £15m of financial benefit to the system.

The team is now at the end of this phase. Working with the pilot PCNs, some important opportunities have been identified to use PHM approaches to transform outcomes for older people, focussed on how the right intelligence is provided to the right people and teams, which is then used to identify, co-produce and deliver interventions, and measure the impact of delivery on patient and system outcomes.

LOCAL EXAMPLE: VIRTUAL WARDS

Virtual Wards are receiving strong support nationally and NHSE is seeking to expand the care delivered through them. ICSs have been asked to deliver 40-50 virtual wards 'beds' per 100,000 of the population by December 2023 with £200m of funding available nationally for 2022/23, and £250m on a match funded basis for 2023/24. However, local delivery and outcomes remain variable.

This partnership took an approach of starting with outcomes for a data-driven assessment of how it could deliver improvements to its virtual wards offer. For this system, NHSE's recommended concentration of virtual wards resulted in a target of 450-600 beds, against an existing baseline of 165. It was important for the local team to understand fully the outcomes achieved by virtual wards and why, rather than rigidly scaling up to the suggested number (which would have risked the pitfalls of an 'outside-in' approach, starting with the solution and not with the outcome).

The specific focus was to understand:

- Are great outcomes being delivered from virtual wards, that improve the health and wellbeing of our patients?
- Is independence being maximised?
- Are infections being minimised and functional decline being prevented?
- Are readmissions being minimised?

With a strong outcomes-first narrative, the team built an evidence base of what outcomes were currently being achieved and what the levers were:

FUNCTIONAL DECLINE	SOCIAL CARE OUTCOMES	INFECTIONS	READMISSIONS
Patients are up to 8x less likely to experience functional decline whilst in a virtual ward compared to equivalent treatment in an acute setting.	23% of patients treated in a virtual ward achieved a more independent social care outcome that they would have in an acute setting.	Patients are up to 5x less likely to acquire an infection when treated on a virtual ward compared to an acute setting.	Up to 2.5x fewer patients treated on a virtual ward are readmitted to frailty beds than the national acute benchmark.

This galvanised staff around the outcomes they are seeking to achieve (and want to ensure that they continue to achieve), before addressing the capacity and utilisation of the service. The evidence will allow future benefit to be quantified, as well as providing a means to measure performance against outcomes as the service is scaled up.

The team was then able to find evidence to illustrate the potential to improve capacity and utilisation, while maintaining the desired outcomes, quantifying the opportunities for improvement:

- Improved referral rates – with opportunity to increase total referrals by 173% by building the knowledge and confidence of referrers.
- Capacity improvements – with an opportunity to increase capacity by 65% by focusing on discharge delays, staff scheduling and ways of working.
- Consideration of key enablers – including culture, supporting data, tools and technology, performance visibility and governance, clinical leadership, aligned pathways, practice and process and capability of key staff.

The system is now planning a focused transformation programme to achieve improved outcomes for 1,350 people per year and free up approximately 50 acute beds over the next 12-18 months.

HOW VIRTUAL WARDS CAN HELP – A PATIENT STORY

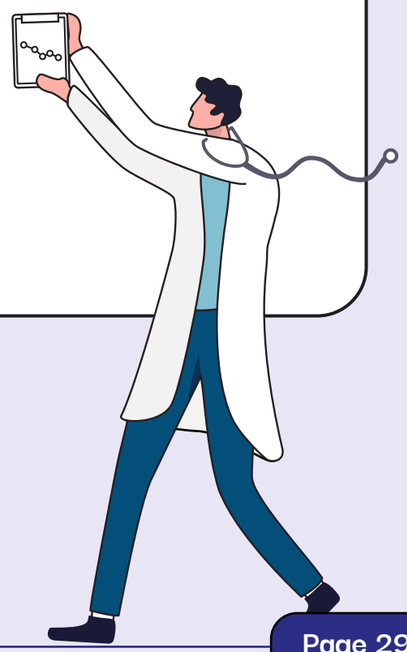
Margaret is 83 years of age and lives at home with her husband Ted. She has a past medical history of osteoporosis, breast cancer, severe COPD, arthritis, CCF/LVF, a chronic renal condition, and endometrial cancer. Margaret was admitted to the local acute hospital for exacerbation of COPD in December 2021 and discharged in January 2022. Since Margaret's discharge, the Virtual Frailty Ward had opened in the community. Margaret's mobility deteriorated during her admission to the local acute trust and she was living downstairs, unable to mount the stairs even with Ted's help.

Margaret's GP was concerned as she was deteriorating further. She was unable to walk, and her legs were very swollen. She was referred to the Urgent Community Response Team who made an assessment and consulted the Frailty hotline for advice, seeking an admission to the Virtual Frailty Ward.

The nurse, therapist and consultant on the Virtual Frailty Ward reviewed Margaret and completed a comprehensive geriatric assessment. They instigated a reduction of some of her medication and put in place a rigorous system of monitoring. Ted was able to express his concerns to the team about Margaret's deterioration. He was particularly worried about her mobility and the reality of her being confined to downstairs living.

The medical interventions were effective over a period of a couple of weeks and so Margaret began to feel much better. Encouraged by this, she became keen to improve her mobility and began working hard with the therapists. Through undertaking the therapy at home, Ted was also able to support Margaret during the sessions and they were able to work with practitioners to set realistic longer-term goals. By practicing on her own staircase, the therapy provided by the Virtual Ward team served to build Margaret's confidence at home, enabling her to go back to living normally, accessing all of her house.

Empowering patients and their families is a vital element of the Virtual Frailty Ward, so an individualised home exercise programme was given to Margaret so that she and Ted could continue therapy once she was discharged.



Overcoming barriers to delivery

Throughout this programme, leaders and systems have been engaged at various stages in their journey towards integration at place. Leaders have been clear on the need to move from ambition to delivery and see tangible, measurable benefits from new integrated arrangements at place. However, the practical challenges to delivery in a complex environment are numerous. Five common barriers were frequently cited:

- **WORKFORCE PRESSURES**
- **COMPETING DEMANDS AND INCENTIVES**
- **NAVIGATING GOVERNANCE AND MOVING BEYOND A FOCUS ON STRUCTURES**
- **LACK OF JOINED UP DATA AND INSIGHT AT PLACE**
- **HISTORICAL WAYS OF WORKING AND BEHAVIOURS**

Some of these barriers will be more applicable than others to each provider and each place. While most systems will have encountered at least some level of challenge from all these areas, one or two of them may stand out as being particularly relevant in their context.

Prior understanding of (and early planning for) these barriers has been key to success for many places. Conversely, where places face these issues deep into a change journey, they can encounter real difficulty. It may not be possible to pre-emptively address barriers in their entirety, but it is often possible to address aspects of them. The concept of “going slow to go fast” was shared by, and resonated with, many of the systems.

For each of the common barriers highlighted, the experiences of the systems engaged in the programme have been synthesised. By doing so, some practical pointers for overcoming the barriers are shared and, where applicable, a selection of operational case studies of how places are working in new ways are included.

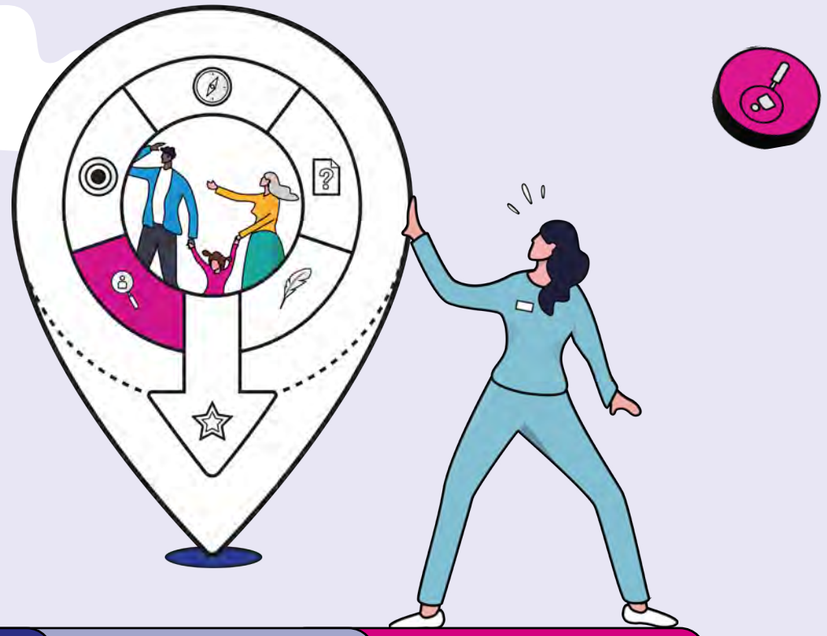
Overcoming barriers to delivery

Workforce pressures

Place-based partnership working requires new and optimised services that focus on the best, most seamless care for patients and service users. Leaders engaged through this programme consistently articulated that this requires them to work with their teams to re-imagine the skills, knowledge, and expertise required to deliver outstanding care, and leverage innovative digital solutions to help them achieve even greater impact for people. It can involve their teams working in ways which redefine organisational boundaries.

Achieving this often requires significant changes in how teams work together, moving skills to different settings in the community, and addressing funding and other resources (such as estates) between organisational and system budgets. These moves have been cited historically as a significant barrier to the success and pace of change.

In the current economic context, health and care workers are under immense pressure, juggling high workloads, partly due to high staff vacancy rates, increasing demand for care, and seeing their remuneration fall in real terms. Leaders have signalled that partnership working will require them to be even more creative, bold, and courageous in their aspiration and actions to build the health and care teams of the future.



WHAT IS THE REALITY? CHALLENGES BEING FELT BY LOCAL SYSTEMS

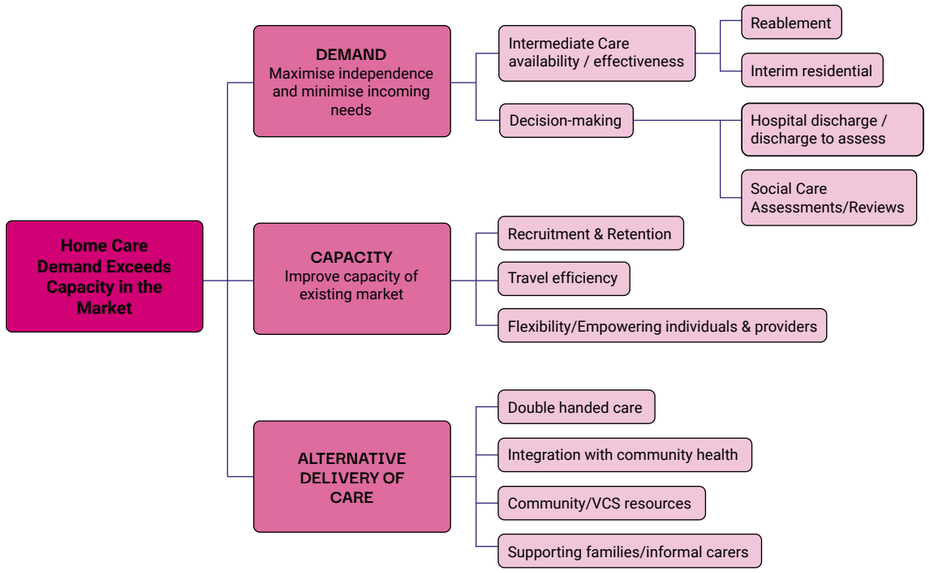
- New ways of working are likely to require additional skills, roles, and ways of working to those historically used in the NHS.
- There is a general workforce challenge across systems. There is considerable pressure on several skillsets, for example, therapists and community nursing as well as HR staff, estates, IT, and ambulance call handlers. This is compounded by gaps in long-term strategic workforce planning at a national level.
- Workforce and financial data are held by different organisations across different systems and formats, and are not structured in a way that is easy to join up across place.
- Existing workforce roles may not sit neatly with one place. Instead, they may be spread across many organisations. For some skillsets, there may not be the scale required to operate efficiently at an individual place level.

HOW ARE SYSTEMS OVERCOMING THE BARRIERS?

One approach being taken is to make sure all possible levers to mitigate the recent workforce pressure are being explored. There has been severe pressure on domiciliary care provision in most systems since late 2021, driven both by demand and a lack of capacity. One system shared its approach to resolve this.

There was an initial focus on capacity: recruitment, retention and efficiency of care providers. This is an important part of the equation but one which the system could not turn around quickly. At times it felt helpless, with a sense that there were no further avenues to explore to find more care workers.

The system then looked at the demand side of the equation. By looking at both the drivers for demand on home care and alternative ways of delivering the care service, the team was able to methodically explore opportunities to reduce demand on services, alongside the existing focus on building up and retaining capacity.



Although many areas of demand reduction had been the aim of previous work and had been working well, this new approach allowed further opportunities to be identified, quantified, and prioritised. The work to increase capacity in care providers was estimated to deliver an additional 7,000 hours of home care within six months. By challenging all the levers on demand, a further 7,500 hours were identified that could potentially be released.

SHARED LEARNINGS ON PRACTICAL TOOLS AND APPROACHES

The following learnings have been drawn together based on the engagement and input into this programme of work.

Think strategy, as well as tactics

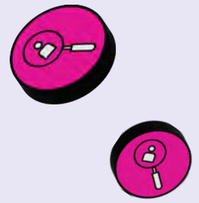
Consider the nature of care that is required, both currently and over the next 5-10 years. Undertaking a strategic workforce planning assessment may be a helpful mechanism to understand some of the long-term changes to the types of role, skills, and the capability and capacity that will be required. With this information, a clear plan for recruitment, retention, training, and education can be deployed to deliver the workforce roles and teams of the future. This could also help inform national level interventions on workforce supply.

Challenge wasted capacity

In thinking about a team's capacity to provide care, explore and identify any waste. Sub-optimal systems, processes, and planning can often mean that teams spend time on activity other than delivering care and contact with people using the service. Understanding the drivers of these drains on capacity and eliminating them where appropriate, guided by the teams themselves (who often have the deepest understanding of where and why inefficiencies develop), can help to release capacity.

Continue to focus on demand

While focusing on making teams as efficient and effective as possible is important, investing time to understand the drivers of demand on services is critical. A continued focus on consistent decision-making, preventative care, and effective intermediate care can reduce pressure on services as much as finding more capacity in the workforce. Thinking creatively about how patients can be treated, successfully and sustainably, in lower acuity pathways, is a win for the patient, while also releasing resources to benefit those most in need of the services.



Competing demands and incentives

As leaders drive forward with the challenging task of redesigning sustainable services, it is clear that they frequently face a complex ethical and economic tension about where, when and how resources are best allocated.

WHAT IS THE REALITY? CHALLENGES BEING FELT BY LOCAL SYSTEMS

Individuals engaged through this programme referred to the fact that being a provider trust executive director and also involved in leading at partnership level introduces tensions that are not always easy to reconcile.

Directors of organisations (bodies corporate such as ICBs and provider trusts/FTs) have legal duties to act in the best interests of that organisation. Place-based partnerships are not organisations in law and so directors of provider trusts who are also part of a partnership leadership team would always retain their duty to their own trust. However, decision-making at partnership level should reflect the agreed intentions of the partner organisations' boards, with reference back to those boards should decisions be likely to impact the provider organisation adversely, and so insurmountable conflicts of interest or loyalty should rarely arise.

There are genuine tensions to resolve between partners when making decisions that affect different organisations, and indeed patients, within any integrated care system or partnership – and so building trust and ensuring alignment of purpose is critical to ensure partners can have open, honest and at times challenging conversations. In the current context, some leaders said that at times they have little choice but to focus leadership and management bandwidth on the challenges they face that day, with little time or resource to creatively develop models of care and ways of working for the long-term.

Case Study: Bolton

For several years, Bolton has been developing more integrated ways of working between partners. The Integrated Care Partnership has successfully brought together delivery partners in an alliance model to allow clinical and operational teams to work more closely together and better meet the needs of the local population. Through this place-based partnership, Bolton have an effective neighbourhood model bringing together professionals from a range of services to deliver tailored services in local communities.

From July 2022, clinical commissioning group (CCG) staff have been locally led through the Bolton Place Based Lead, the CEO of the local Foundation Trust. Bolton has a blended model of leadership with the chief executive of the NHS Foundation Trust serving as place lead, and the integrated place partnership has a Managing Director who is also the Director of Adult Social Services at Bolton Council.

The maturity of joint working and strength of leadership alignment behind the model in Bolton gives it an excellent platform to build from, and is now turning its attention to outcomes. They are aware of the challenge ahead to make sure the integrated arrangements deliver better care for the population.

"Our Integrated Care Partnership has been an excellent vehicle for joint working and building relationships. We have been focusing on strategy for a while, but now we need to become the delivery arm of the locality board. I can't yet show all of the outcomes we have delivered for the public, but we need to start to show that now."

Bolton has seen wider areas of collaboration forming around the core service delivery, such as:

- The Bolton Research and Innovation Network (BRAIN) has brought together all informatics teams across partners to look at how they can share and use data to address inequalities and improve outcomes
- A digital partnership board has been set up
- Communications and engagement teams and strategies have come together across partners to ensure clear and consistent messages to residents and staff

The real power of the model, the team in Bolton say, has been the change in culture and conversation around resources and finances. There is a real sense of team forming around health and social care, it is feeling less clunky between organisations and individuals, and things can be decided and moved around more quickly. Discussions are no longer about the commissioner's part and the provider's part, but about how all partners redesign the single system.

The CFO of the Foundation Trust has also served as CFO for the CCG for several years, helping to close the gap between commissioner and provider. The integrated place arrangements now mean there is complete openness and transparency, which the team admit can be painful at times. There is a belief that if finances are not integrated, then services will never be fully integrated. The benefits are already clear, with conversations about 'One Bolton Pound' taking priority.

"If we save money, it doesn't matter which organisation gets the benefit. We just want to drive improved outcomes and value for money wherever we can, then move money around the system as needed."

Bolton has made great progress in their integrated arrangements, and this is clear to see in the culture of joint working and a single approach to finances. The competing incentives of individual organisations are giving way to the priorities of the partnership. The challenge ahead to make sure better outcomes are delivered is now the focus of the team.

SHARED LEARNINGS ON PRACTICAL TOOLS AND APPROACHES

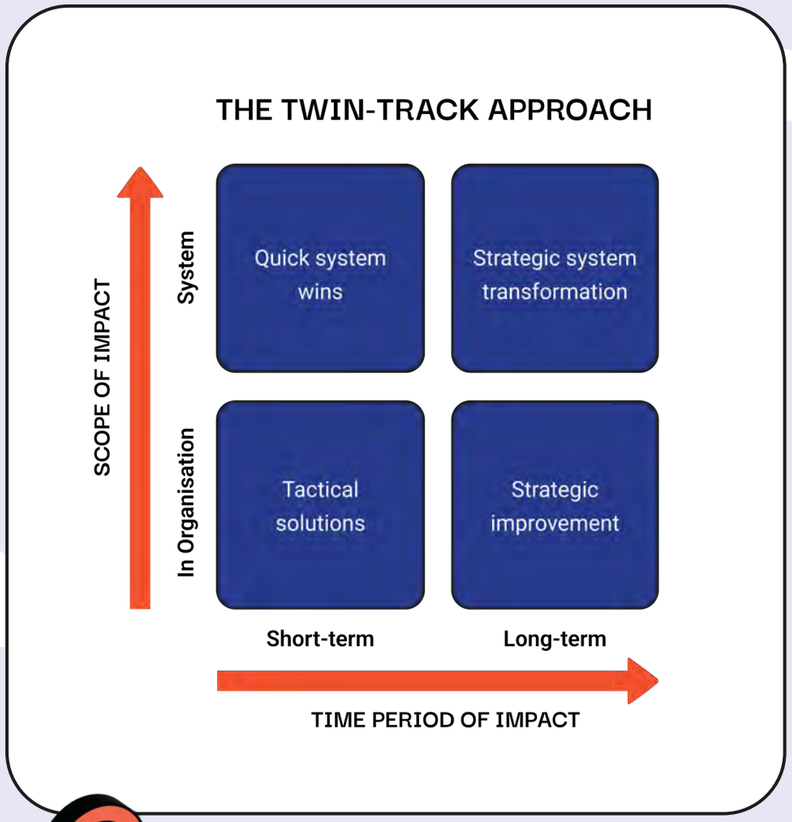
The following learnings have been drawn together based on the engagement and input into this programme of work.

Prioritise based on evidence

- A shared evidence base indicating where outcomes could be improved, and by how much, supports partners to focus on changes that can make the biggest difference for patients and service users, operationally and financially (see section on 'starting with outcomes').
- Programmes of this kind need to be realistically resourced – both in terms of operational management capacity and senior leadership involvement. Successful place-based integration requires significant input, with – as a rough guide – a 0.5 full time equivalent commitment at senior director level and dedicated resource among service managers running those services. It is essential to regularly check in with partners on system priorities. Establish each partner's key change priorities and, for example, the top three priorities for the system and review these on a regular basis.
- Strong leadership is required to broker agreement and facilitate sensible prioritisation decisions – that includes taking decisions about sequencing of change initiatives through the life of the programme.

Allocate required resource for long-term and short-term priorities

- The systems that have progressed most quickly have been able to create the space (operationally and financially) to do some transformational work that can support longer-term sustainability, while maintaining a focus on operational management. Balancing the demands of short-term operational imperatives and long-term change requires a solid structure, if progress is to be achieved on both. Consider a twin-track approach, where each have their own allocation of resource, project management, and leadership. Priorities within each group are agreed by asking "what does the system need to achieve in the short-term and in the long-term. And what does the organisation need to achieve in the short-term and in the long-term?" Avoid running short-term and long-term programmes in isolation – they can be designed to support each other. For example, responding to short-term pressure can be achieved in a way that sets the foundations of behaviours or ways of working to achieve the long-term vision. Similarly, the long-term programme can be designed in a way that delivers tangible support to operational teams as soon as possible.



Plan for resolving disputes

- System leaders know that balancing these competing demands and incentives is not straightforward. Compromise is often required in partnership working.
- Set out a plan for discussing and resolving disputes early – there will be some. The plan can also provide an opportunity for partners to revisit priorities, maintaining alignment on the short- and long-term.
- Consider independent facilitation for dispute resolution – it is unrealistic to expect any single leader within the system to be perceived as having a neutral view across health and care.
- Recognising challenges will arise can support navigating them – assuming good faith among partners and an understanding of each organisation's different accountabilities and incentives. At the same time, keep the original vision and system benefit at the forefront of the conversation.

Build alignment and system design principles and maintain them even when times are tough

- Invest time and effort in the development of a coherent strategic vision for the system, that gains the active support and genuine commitment of the leadership teams of all the constituent organisations. 'Go slow in order to go fast' - take the time to think through the way in which decisions will be made. If the process is undertaken in this way, when systems face challenging situations, as inevitably they will, they can be tackled against a backdrop of trust, governance, and accountability, which supports the best decision possible to be made.

> *"We need a way to stay friends and colleagues but fix these issues. We need the space to have these conversations frequently and openly. That requires depth of relationship and trust."*
>
> Chief executive, NHS Trust

Be clear on investments and benefits

- Work through where resources are required for new models of delivery or initiatives rigorously. Establish where the funding will come from, and which budgets accrue the benefits of the transformation.
- Reallocation of funding may be required between partners. Retain the focus on the outcome required and be prepared to think flexibly about routes to achieve this. As an example, where shared funding or pooled budgets are the goal, then perhaps a Section 75 route can support.
- A dedicated finance lead for the change programme – who understands the aspirations, the operational changes, and has dedicated time to input into the programme – can add real value. Their perspective can help with foregrounding the resource allocation tensions.
- A system benefits/system resources group of finance and operational colleagues should be set up to explore and understand this landscape in detail, acting as an advisory group to system leaders.

Navigating governance and moving beyond a focus on structures

Provider boards need to ensure new partnerships and associated programmes of work are embedded within their governance arrangements, to maintain oversight of activities and progress.

At the same time, partners will need to establish structures and processes to enable effective planning, development, and delivery of work programme(s).

Leaders engaged through this programme regularly talked about the importance of good governance. Ensuring good governance – that the boards of the organisations involved exert appropriate control over the partnership, the activities of which they retain legal liability for – and setting up structures and processes to manage a partnership, are linked but importantly distinct activities. Being clear about this can help to navigate the space.

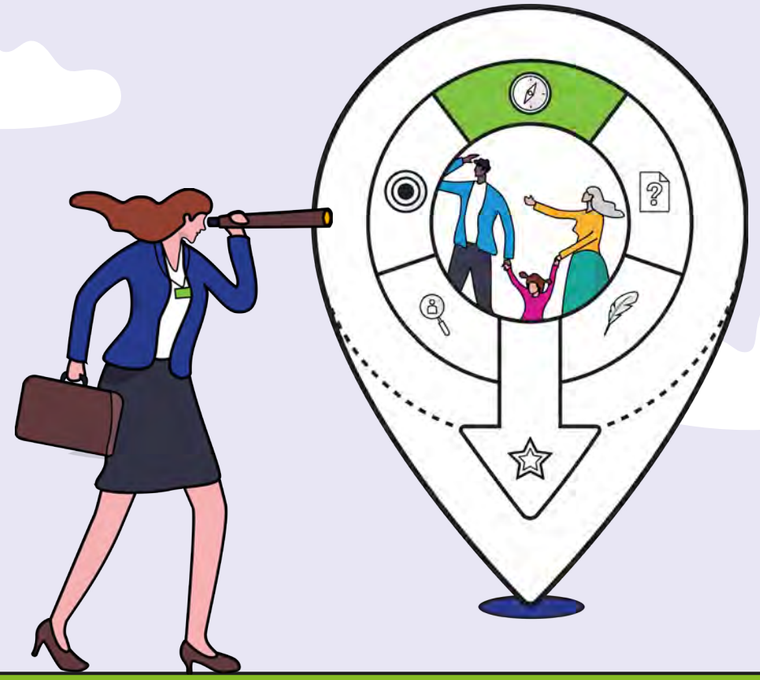
Each organisational player involved in integrated working will have its own organisational governance (that is, system of leadership and internal control), and unless partners have formally merged to create a new organisation, oversight of place-based integrated structures should be undertaken through the existing governance structures of each organisation.

Partnership working to achieve specific outcomes is usually a question of having effective programme or project management in place, including clinical oversight – so the leadership, control, and performance monitoring of most partnerships' activities will happen through programme management.

Governance of the partnership requires agreement between partner boards regarding the degree of reference back to the boards that is needed to make decisions and to escalate to those boards any areas of risk to the partnership or its activities, and clarity about the extent of delegated authority that executive leaders running the partnership's operational activities have from their board.

Below the level of the partners' boards, partnership management structures will be set up to plan and run the programme(s) of work.

Leaders involved in partnership working note the draw it can make on their capacity, and that complexity can creep in, with a focus on setting up structures and processes rather than progressing the aims of the partnership programme. Embedding reporting/reference to provider boards in their existing governance structures should minimise any requirement for additional structures to enable board governance of the partnerships' activities. The management structures set up below should be proportionate to the work being undertaken and need not be overly complex. All arrangements should be subject to review and evolution as required: if things are getting complicated, change them. Using the expertise of governance professionals within the partner organisations at the outset should help.



WHAT IS THE REALITY? CHALLENGES BEING FELT BY LOCAL SYSTEMS

- Existing organisational governance structures can be perceived to overlap with place-level management structures and processes designed to drive specific change programmes.
- Staff are being asked to join or service an increasing number of forums (both organisational and place-focused), when capacity is under pressure.
- Places are bringing together a complex web of services, delivered by a distributed network of staff, so being clear on oversight arrangements and how risks are managed and delivery monitored is not straightforward.
- Organisations working together at place may already have teams and initiatives working on related challenges, but it can be hard for these programmes to have sight of developments and change programmes in other organisations.
- Disagreement regarding where clinical responsibility sits can be seen as a negative risk currency, impeding change.
- Debates about optimal geographies to focus on can cause misunderstanding and slow delivery.
- There is a risk that systems and places confuse management structures with the need for oversight from partner organisations' boards/leadership teams and set about creating new structures without focus on the outcomes.
- Multi-agency partnership oversight groups are sometimes constituted so that multiple functions of partner organisations are represented. This can lead to groups of 20 or more participants, where responsibility becomes diluted, and decision-making is slowed. Be clear who needs to be in the room and ensure they have authority to take decisions.

HOW ARE SYSTEMS OVERCOMING THE BARRIERS?

Some leaders reflected that they are managing to effectively navigate a changing landscape in recent years and are in a strong position to progress delivery.

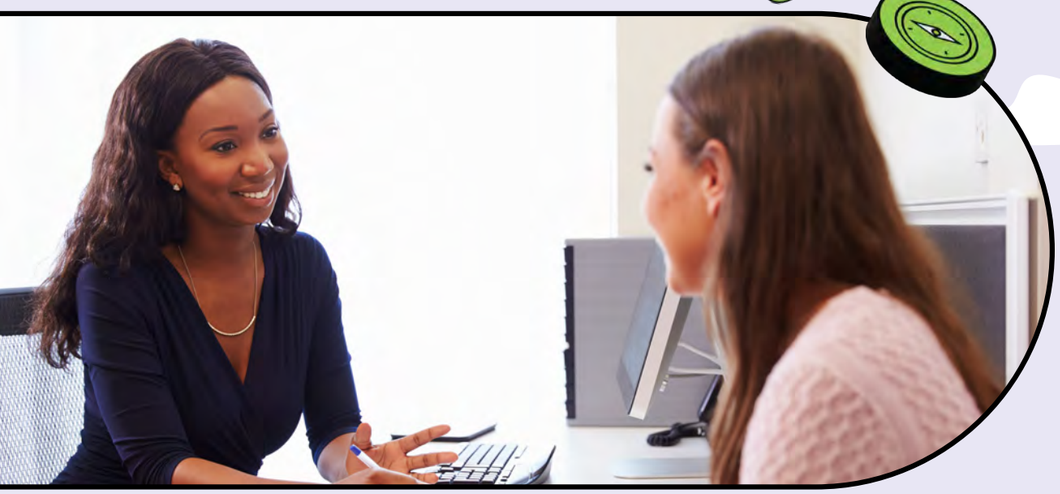
Key learnings for success include:

- Clear joint decision-making arrangements, a set of agreed strategic priorities shared by partners, and dedicated leadership resource.
- A small number of priority work programmes, with specific deliverables linked to outcomes.
- A realistic investment in workforce and transformation.
- Executive leads for each work programme, supported by multi-agency thematic leadership groups to drive delivery.

"The examples of integration that work can talk about integration of service users and clinicians, or integration of the population with services, or services with services. There is a risk that in navigating changing governance arrangements, we orientate around structures, that we integrate ourselves but not our population."

Chief executive, community and mental health trust

For more details, a recent NHS Providers report on place-based partnerships explored how partners in a small number of places are coming together to take decisions and drive forward delivery.



SHARED LEARNINGS ON PRACTICAL TOOLS AND APPROACHES

The following learnings have been drawn together based on the engagement and input into this programme of work.

Focused and effective programme governance

- Keep the programme management and clinical governance focused on the practical changes and work to be achieved, with the right people in the group who will be able to move towards that goal. This may sit within existing forums at place.
- The programme management team is responsible for delivering the outcomes, the organisational partner boards remain accountable for the existence of the partnership/its objectives (bear in mind the principle of the inside out approach – set up governance and management structures based on outcomes, rather than process).
- Governance arrangements need to balance oversight and effectiveness. Partner organisations need to be engaged, but there are risks from discussions with too many people in the room to be effective. Reporting to partners can be risk-based and proportionate – escalating where high-risk, or high-value decisions are being taken to ensure robust oversight.
- Where decisions are taken through delegation from partner organisation boards, representatives should be clear about the limits of their decision-making authority, reporting requirements back to their boards. Partner boards should be sighted on any intention to change strategic direction in terms of the aims of the partnership.

Keep it simple and get started

- Ensure governance arrangements are designed into the change programme from the beginning. As part of the design and mobilisation phases, use governance professionals' expertise to work through and agree accountabilities and responsibilities with partners.
- Be prepared to tweak and iterate governance and programme management arrangements as programmes move through different phases.
- Simpler management arrangements tend to be easier for teams to work in, with greater clarity on reporting providing more effective oversight.
- Where possible, embed governance into existing structures, rather than adding to them.

CASE STUDY

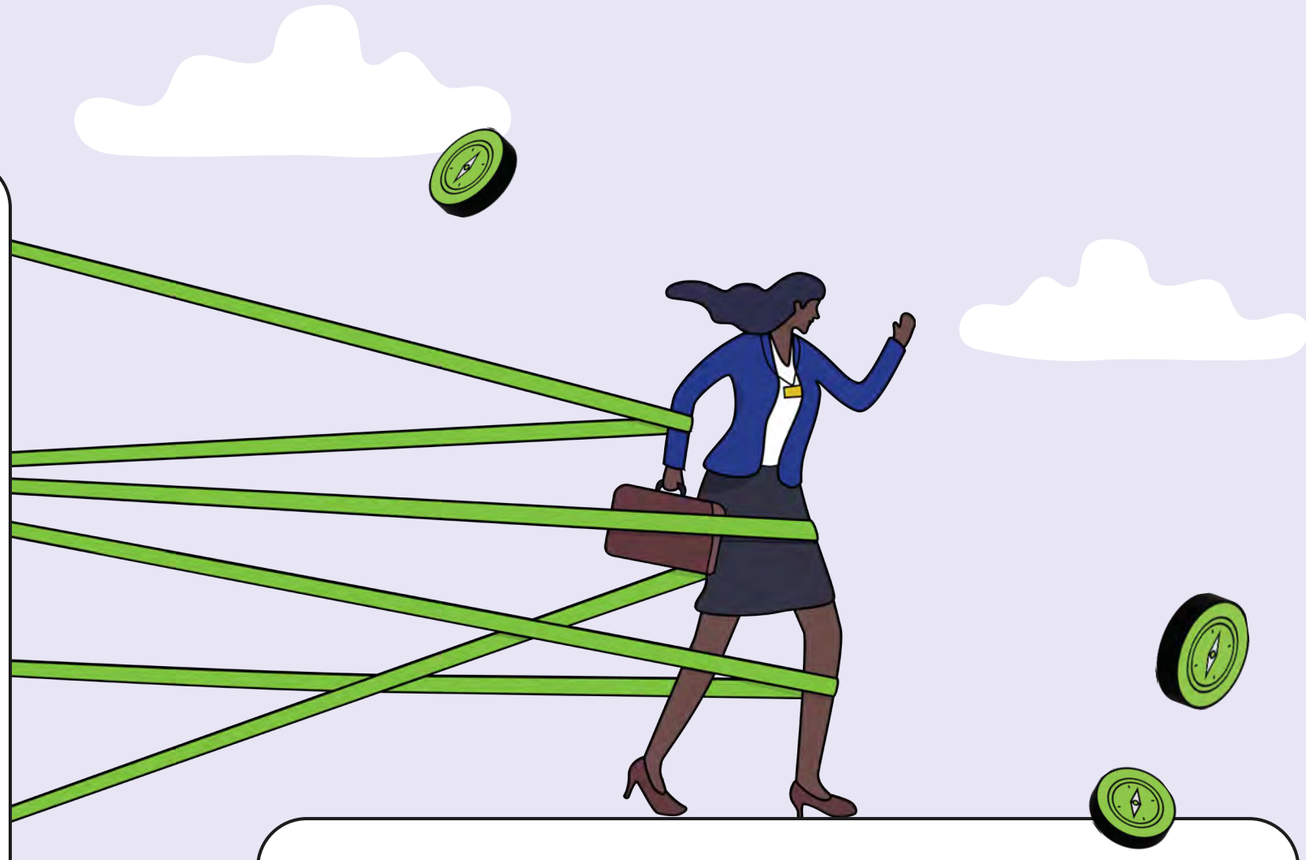
Moving from ambition to delivery in Bradford District and Craven

The Bradford District and Craven Health and Care Partnership is progressing a new phase of integrated community working, through a priority workstream focused on health communities as part of their "Act as One" strategy. This is one of their five priorities that the partnership will be focusing on following its strategic priorities re-set programme, which is currently being finalised working closely with colleagues and partners locally.

There has been a history of innovation, partnership working, and a focus on trying new ways of working across the Bradford District and Craven place-based system. The partnership contributed to the NHS Providers Collaborate report in 2021, demonstrating how its 'Act as One' ethos is really driving a unique approach. This has built strong foundations for integration at place, but leaders shared how they are looking to add further clarity around measurable outcomes, in line with some of the approaches described in this programme.

The partnership has created and shared a strong purpose – to **invert the power to act** – which has given clear direction and a strategy for moving into delivery. In relation to the healthy communities workstream, this means a focus on a small number of things, informed by evidence, for each part of its population. The partnership will work with local neighbourhoods to identify what outcomes matter to them, providing opportunities and resources to deliver change on small footprints that will combine to reduce health inequalities across the place.

The delivery model includes the development of 'locality collaboratives', consisting of GPs, mental health, community nursing, social care, the voluntary community and social enterprise sector (VCSE), dentists, optometrists, and community pharmacy. There will be six locality collaboratives within the place, helping to move decision-making closer to communities and to agree local priorities to reduce health inequalities across the 13 smaller community partnerships (similar to PCN footprints). The aim is to shift focus to integrated teams at community, locality and place, providing an opportunity to build services and allocate resources to fit the needs of its communities, recognising that needs vary with a place and informed by a granular understanding of local populations.



The partnership knows that around this approach, they need '**measures that matter**'. This will involve the development of common models, used to describe the process and outcome metrics for each footprint. There is a desire to ensure these metrics are as meaningful as possible to the outcomes people want, so they are measures that matter to local communities. The partnership is using innovative approaches to gather data and intelligence from its communities. One recent example of this approach, led by the Citizens Forum, has been the launch of the ***Listen In*** programme. This not only supports the work prioritising healthy communities, it also helps the place-based partnership board to understand more about what matters to people.

Detailed work has begun to define the outcomes and measures for Bradford District and Craven, and the approach will be developed in local communities for new integrated ways of working over the next two years. Leaders hope to create the infrastructure for an integrated model of health and care and to make significant improvements to health inequalities.

Lack of joined up data and insight at place

All sites engaged in this programme recognised the value of high-quality data in supporting integration. They agreed that data is a vital part of running effective health and care services.

Used correctly, the latest digital tools can give frontline teams live information to support better decision-making and give leaders greater understanding of service challenges and opportunities, to support and effectively prioritise resources.

However, a lack of joined up data and insight that is trusted and meaningful to all partners had been a challenge faced by several sites.

When implementing new integrated ways of working, it was found that leaders in systems that understand performance and outcomes are consequently able to understand if the changes are achieving the high-level success measures and give operational teams and managers a more real-time view of performance to inform decision-making.

WHAT IS THE REALITY? CHALLENGES BEING FELT BY LOCAL SYSTEMS

Many ICBs or local systems have put significant effort into establishing data and digital strategies and responding to national assurance requirements. However, those engaged in this programme often reflected on how this is yet to translate into truly useful insights and information that is used every day, with some feeling a long way off a 'single version of the truth' that is trusted across the place. Challenges being felt by local systems included:

Systems and data

- Interoperability: partners have different data flows, and local reports may be built in different ways with contrasting interpretations, showing inconsistent impressions of performance. There are varying levels of digital maturity across systems and partner organisations.
- Place-based teams often do not have access to data at the right level to demonstrate outcomes tied to a specific initiative.
- Linked data sets are not always available and creating them requires aligning information governance.

Objective and useful information

- Systems often lack a single source of truth that can be accepted by all partners, to make decisions on priorities.
- Without the right level of visibility, debate can focus on anecdote and perception, especially across different partners, rather than based on objective evidence.
- Data gathering is often designed to generate high level oversight measures. These do not necessarily reach or drill down to measures that support day to day ways of working for teams.
- Data isn't always "live" and is often reported with a lag, which reduces its value for operational decision-making.

Capacity, capability, and culture

- There can be a divide between digital, data and technology (DDaT) teams and operational or clinical teams, with tools and dashboards made without input from frontline teams.
- Digital tools may have been built or procured without strong engagement with operational teams, leading to gaps in understanding and missed opportunities to harness their capabilities. Focus is often on large scale data schemes, such as joint patient records or data lakes and infrastructure, without necessarily having clarity regarding how those capabilities will be used on the ground to support improved outcomes.
- Business Intelligence (BI) teams are often stretched given the increased appetite for data locally, as well as responding to the national data agenda and mandatory reporting.

Case study: Joined up data and insight at place

Northamptonshire Health and Care Partnership is progressing a programme of partnership working focused on acute and community settings to transform health outcomes for Northamptonshire's over 65 population. The programme aims to increase the independence of older people by redesigning pathways to ensure people are getting the right level of care or treatment, in the right setting, for the right amount of time.

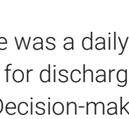
One of the biggest challenges facing the system was visibility of data. There was no clear view of the pathways out of hospital people were using, the reasons for delays on each pathway, and where partners could focus to support flow and improved outcomes.

When the new discharge to assess (D2A) policy was put in place, there was a daily call instituted with all providers to discuss patients who had been referred for discharge that day, agree a pathway, and progress the onward referral and transfer. Decision-making and flow were hampered by a lack of oversight of the eventual outcome for the person, and limited visibility of the biggest points of friction causing delays to transfer of care following an initial decision.

Pulling the relevant data together into one place posed significant challenges for the system, including data quality at the source, analytical and digital skills, and prioritising this work appropriately alongside a large number of other transformation projects progressing for local providers.

Through the programme, the discharge process has been redesigned and now incorporates the data aggregation and digital tools required to support daily management and performance improvement. From redesigning forms on wards, to developing ways of working for the discharge team, to building a live dashboard of delays and outcomes, the new discharge process was designed with key staff from all partners.

The integrated discharge team now has visibility of information that did not exist before. For example, the team can see which wards are taking longer to submit referrals to the complex discharge team or which community providers are taking longer to source a package for a patient. The team also has visibility of other valuable insight which was previously not possible, such as time taken to arrange transport for a patient, or average wait time per pathway for current inpatients. All of this is dynamic, allowing users to filter by ward or division and, when needed, drill down to a patient-by-patient view.



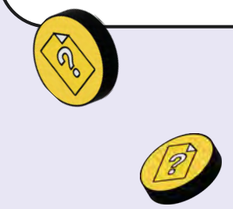
The team's ability to make positive progress on patient outcomes was boosted by the granular breakdown of the current performance day-by-day, enabled by user-friendly data and visuals. The combination of appropriate technology and data and changes to ways of working have resulted in an improvement in hospital flow, reducing post-medically optimised delays by four days for complex discharge patients, and is delivering better outcomes for people.

A unified vision, backed up by support from the senior leadership in the system, was key to overcoming the lack of data and insight. Previously, it took several days to submit and accept a referral via the complex discharge hub, and all leaders, including the head of discharge and chief operating officer of the acute provider, were committed to addressing this. The team also shared the ownership and accountability of delays between the wards themselves and the complex discharge team, resulting in a truly collaborative effort to drive down post-medically optimised length of stay.

To date, the partnership has reduced pressure by approximately 40,000 bed days across the system (equivalent to 110 beds that would have needed to have been stood up). With ongoing refinement and delivery, leaders estimate the programme can deliver a reduction of between 68,000 and 85,000 bed days in total, which given the demographic and economic pressures, will be needed for the system to remain manageable.

"The data means we can make evidence-based decisions where in the past we made anecdotal decisions and therefore the actions we took were often misplaced and didn't improve pressure. With the new information we can make very different decisions."

Chief executive, local authority



SHARED LEARNINGS ON PRACTICAL TOOLS AND APPROACHES

The following learnings have been drawn together based on the engagement and input into this programme of work.

The need for unconstrained thinking

- Data barriers have existed for many years. While there are many lessons to be learnt from the past, it is nevertheless easy to be limited by previous solutions or old problems.
- Bringing together operational teams with BI or data teams has been a positive step for many. Where these teams are embedded within a partnership arrangement or working closely with each other, there can be gains in mutual understanding; operational staff can better understand the art of the possible and data teams can better understand what is useful day-to-day, and how data and insight will be used in practice.
- Senior leaders have a role to play in supporting and empowering their teams in this space and promoting the value of joining up operational and data insights to improve services.

Single version of the truth

- Systems should aim for consistent reports that are relevant to the integrated services; these are widely shared and acknowledged as a single source of truth by all partners. Operational staff can access support in harnessing data in their daily ways of working and use it to make decisions.
- Most progress has been seen where pace and action are prioritised above perfection. Digital strategies can paint a future with many features, capabilities, and an abundance of data. Prioritising the measures needed, ideally those linked to the target outcomes, and focusing on the 'minimum viable product' rather than generating a suite of dozens of KPIs, can bring earlier results. This process can also serve as a catalyst for delivery of further useful and trusted performance data, once the barriers have been broken down.
- Check that the measures chosen are the 'top level' measures for the system and speak to a range of needs and priorities among partners. They should be linked to overall outcomes and system benefits.

Outcomes-based performance culture at every level

- Staff in health and care services are generally motivated to achieve the best outcomes for individuals. If 'performance' is linked to this, it can support better results and team morale. For example, where a team leader can see the interventions given to patients by a community team as well as the outcomes for these patients, they can take regular action to improve decision-making and the quality of interventions.

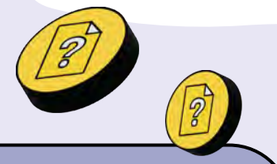
Creating an outcomes-focused and data-informed performance culture can have a considerable impact. If done effectively it requires:

- Tangible KPIs, simple to understand, that are well-defined and clearly linked to achieving better outcomes for people.
- Regular access to up-to-date data on the performance against these outcome measures.
- Ensuring that service managers and directors understand the dashboards, including how to use them to identify priorities, take action, and celebrate success.
- Establishing clear links between levels of governance, where performance data is viewed, and where it is challenged at the higher level. Frontline teams are empowered to challenge and improve performance and escalate issues where necessary.

When this performance culture is working well, each level from frontline to board has:

- Visibility of their outcomes-based measures of success.
- Analysis that informs action at appropriate pace (which in some cases may even be on a daily basis).
- Resources and autonomy to address issues and improve performance, informed by data.
- Clear responsibility to interrogate their performance data, along with accountability to continue seeking improvements in performance.

Building this culture brings a stronger desire from all teams to be able to access clear, trusted data and insight, while aligning a wider group of staff to break through this barrier.



> *"The team has responded much better to a measure of 'how many people did we support back to their own home this week', rather than 'how many assessments did we complete' – it's clearly linked to outcomes and means more to the team."*
>
> Operations director, Community Provider

Historical ways of working and behaviours

Health and care systems have developed and changed over decades. The course of innovation and improvement has brought huge gains in service capabilities, but has also brought complexity and a history of ingrained cultures, habits, and expectations. There are hundreds of examples of this, many of which were shared as part of this programme:

"It has never been the role of this organisation to carry that risk."

"I'm a community nurse / social worker / therapist / GP, it's not my job to do that."

"Our arrangements with this provider have always been this way, that's just how the contracts work."

Deep rooted histories, whether that is between organisational cultures and leadership styles, or the way that different professions work with each other day to day on the frontline (informed by clinical regulations and licenses), require careful consideration when delivering place-based integrated services.

WHAT IS THE REALITY? CHALLENGES BEING FELT BY LOCAL SYSTEMS

- Often, organisations' patient and service user flows are not neatly coterminous with place.
- Local health and care organisations view situations from different perspectives and operate with different drivers and constraints. For example, health teams operate within a context of national targets and a centrally led architecture, via an annual planning cycle. Local authorities, alternatively, are politically-led and accountable through local elections, are legally not able to over-spend on a budget, and generally operate based on medium-term financial planning.
- "Outcomes-based and person-centred" can mean subtly different things to different system partners and teams.
- Historically fragmented commissioning means that the focus can remain on traditional service interventions rather than developing service models that wrap around the needs and strengths of individuals.
- Coordinating across a broader array of public services to deliver place-based approaches can involve working with housing services and working-age welfare services (and others) and introduces further institutional interfaces where professional groups come together with different traditions, ingrained cultures, and priorities.

> *"NHS organisations and local authorities have different governance structures, different accountability, and different behaviours. We need to understand politics, they need to understand clinicians."*
>
> Chief finance officer, NHS Acute Trust

SHARED LEARNINGS ON PRACTICAL TOOLS AND APPROACHES

The following learnings have been drawn together based on the engagement and input into this programme of work.

It takes time to understand historical viewpoints

- In this work, system leaders shared the time investment required to break through this barrier. At all levels of partnerships, teams reflected on the value of setting aside development time to listen and understand teams coming from different organisations and traditions. In successful systems, senior leaders have been able to explore their past and current drivers, pressures, and even their frustrations with system working. Frontline staff have been able to share their day-to-day experience, how it has changed, what their job now embraces, and their motivations and frustrations. This organisational development work takes time and careful facilitation, but the approach has brought a deeper level of mutual understanding and trust between historically different professions and cultures.

Actively measure the partnership status

- Seek feedback and insight from teams about how they are feeling about the partnership and about their roles. Undertaking this exercise frequently and consistently can allow leaders to identify warning signs and intervene. The engagement of teams can be measured in terms of their understanding of the purpose, their desire and belief that they can deliver, the support they receive, their understanding of new ways of working, and their relationships with other partners at place.
- Designing change that is easy to adopt can make or break new service delivery. Consider undertaking 'day in the life' exercises for the teams delivering the services to generate a map of the level of change it brings from their current way of working.
- Finally, it helps to have realistic expectations of timeframes involved in embedding new services and ways of working across teams. It can take 6-12 months to fully adopt and refine new ways of working in teams.

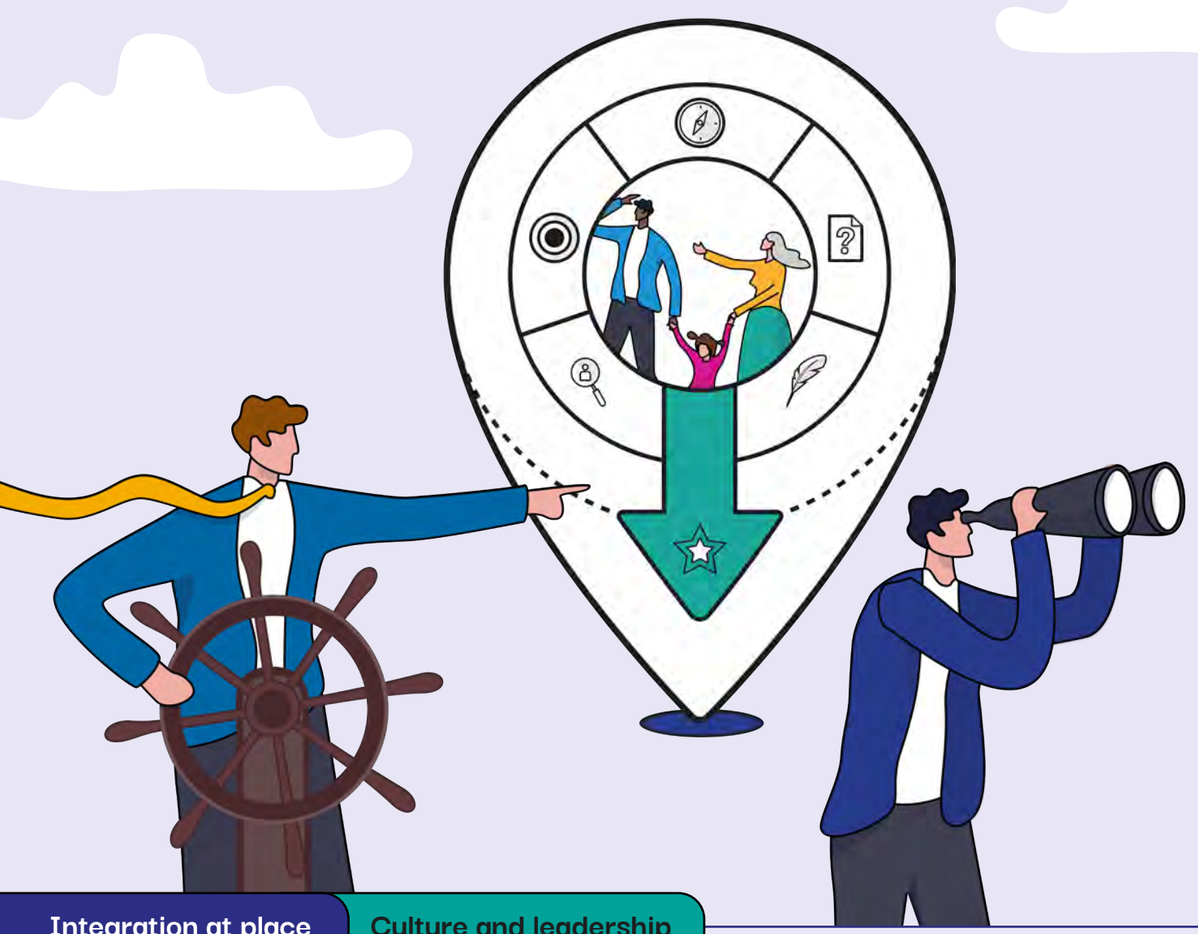
"We should remember the impact of historical hierarchy, both within organisations and between. We have seen a real shift in culture and made big inroads to the relationship between GPs and acute clinicians, which is supporting better care and easier access for patients."

GP and clinical lead of Federation

Culture and leadership

Delivering integrated services successfully, with a firm focus on measurable outcomes and overcoming barriers that may have been in place for many years, demands skilled and creative leadership and a consistent, values-driven culture.

Leaders engaged through this programme shared an acknowledgement that they need to articulate a coherent and authentic narrative for their teams that enables them to see how their own organisations will develop and enhance the service it delivers within the wider system. Leaders have found that the current formalisation of place-based working presents opportunities to respond more effectively to the demands facing health and care systems. They consistently drew out that authentic, collaborative, and inclusive leadership is key to creating the culture and environment that support teams' space to innovate and improve.



LEADERSHIP ALIGNMENT AND SHARED AMBITION

All systems involved in this programme cited leadership as an essential part of successful integration at place. Where organisations come together in new ways, different cultures, with different historical contexts and expectations, meet. Insight from the sites contributing to this work made clear that providing an environment in which these cultures can come together in a spirit of positive collaboration to facilitate the development of new shared cultures of partnership working, required highly skilled authentic leadership.

A common thread to successful integrated working is alignment on a shared ambition. Consider the following:

- Is there a clear narrative? Does everyone understand what integrated working at place will look like and what it will achieve for people?
- Can all leaders in the system articulate the narrative and ambition coherently?
- Will all leaders be supported to afford priority to the change as being equal to the ambitions of their own organisation?
- Is the identity or brand of the integrated agenda at place strong enough to transcend organisational barriers?
- Does the leadership group have a shared set of aspirations and action plans around equality and diversity, informed by an understanding of the experiences of staff from minority backgrounds?

HARNESSING THE DIFFERENT CULTURES

Studies have identified a tendency for different organisations within a system or place to exhibit markedly different cultures. Differences are seen between the varied approaches the NHS and local authorities take to change, performance, management, and delivery.

Ideally, this diversity of cultural norms can be harnessed to bring together wider views and approaches resulting in stronger, even more positive solutions. However, the range of norms can, in practice, generate disagreement and friction.

Leadership across the system from different organisations and particularly at place, must have absolute alignment and clarity on the direction and outcomes, so that differences in culture and approach can then exert a positive impact on the overall work.

WHAT IS THE REALITY? CHALLENGES BEING FELT BY LOCAL SYSTEMS

Systems involved in this programme reflected that while skilled leadership and establishing and maintaining the right culture are perhaps the most important aspects of successful integration at place, they also presented the greatest challenge. Reasons for this include:

- Developing successful partnerships can require substantial time commitment from senior leaders, in addition to their existing leadership responsibilities within their organisation.
- Many leaders have developed and succeeded in a culture which was more conducive to competitive behaviour. The challenge for them now is to unlearn these skills, ways of working and thinking, even though they have served them well in the past.
- Communication can be a challenge across partners. This can result in trust taking longer to build and grow, particularly between health and social care, where different emphases will play out.
- Relatively few leaders have professional experience working in all the different areas of the health and care system. A lack of familiarity with differing sectoral cultures can lead to unintended consequences during change programmes.
- Leaders are managing the pressures and incentives of their individual organisations, which may at times exist in tension with the broader needs of the partnership agenda.
- Partnership working demands a different style of leadership, based on understanding, inclusion, negotiation, discussion, and persuasion. Hierarchy, command, and control may sit well in some individual organisations but will not create successful partnerships. This means that leaders must be able to adapt and develop their leadership styles to be successful in integrating services.

CASE STUDY

The experience of a partnership which contributed to the programme illustrated the importance of building a guiding coalition. The work involved three PCNs forming an alliance, and working with the voluntary sector and community groups across the place to tackle long standing health inequalities.

The secret to success, according to local leaders, was in inspiring GPs, voluntary partners, health and social care providers to form strong community partnerships. This was driven by a skilled, highly motivated individual working in the place – Alex.

Alex stayed true to the vision of the ambitions of the partnership, bringing people together with energy and clarity on the potential outcomes of the work. They created the guiding coalition.

The team reflected that this was one of the most significant learnings – identifying the right people to lead the change and identifying key individuals who will make it happen. Their greatest lesson? “Everybody needs an Alex”.

SHARED LEARNINGS ON PRACTICAL TOOLS AND APPROACHES

The following learnings have been drawn together based on the engagement and input into this programme of work.

Build a guiding coalition

- Establish a core group of leaders, ideally small in number, who share common ambitions, can build trust between each other and between organisations, and make decisions. Embedding independent challenge to the group, or at set points, is vital.
- Take ownership for elements of delivery as a group – working through practical challenges to make delivery happen together will build stronger relationships than conversation and discussion alone.
- Invest in relevant skills development for leaders, either individually or as a team of place-based leaders. Creating space for this leadership organisational development work can give space to build trusting relationships and strengthen the guiding coalition.

Maintain commitment to the vision and outcomes

- Hold strong and clear to the overall vision and outcomes targeted, tracing activity back to this regularly.
- As leaders in the guiding coalition, take the commitment to the partnership back into individual organisations and ensure mechanisms are in place to share and drive the partnership outcomes with teams.
- Ensure that organisations' boards have engaged with the vision and outcomes targeted at place, and that the guiding coalition are in ongoing dialogue with organisations' boards to ensure constructive challenge is embedded into the programme.

Assume the best in colleagues and gather feedback to support adaptation

- Leaders should 'seek first to understand'. The assumption should be that other colleagues are coming from a positive place. The leader's role is to understand why they hold the perspective they do.
- Seek feedback from other system partners and operational teams - and take action from it. Consider setting aside time to step back and reflect on progress so far, share successes, honest concerns, and constructive feedback to partners or between individuals.
- Support leaders in the guiding coalition to engage with data and insight, and regularly interrogate whether the programme is delivering the envisaged benefits and adapt if not.

Celebrate success

- Celebrate success and encourage teams when the right behaviours are seen.
- Prioritise time to do this well and spend time with frontline teams to talk about the success and what it has meant for outcomes.

CASE STUDY

A guiding coalition

The Mid and South Essex health and care system delivered a transformation programme to improve outcomes for older adults. Their focus was particularly on admission avoidance, improved discharge pathways, and more effective intermediate care and reablement along with improved local collaboration for long-term support in the community.

With such a breadth of scope and 15 partner organisations involved, leadership alignment on the purpose and outcomes was essential.

The team achieved this through:

- **A shared belief** in the evidence which illustrated the scope to improve target outcomes. This involved making sure everyone understood the evidence and had opportunities to challenge and discuss, before taking a lead in sharing it with staff from across the different organisations.
- **Clarity of purpose**, in ensuring that each leader in the system could describe the change programme and what it was aiming to achieve in simple language.
- **Joint ownership**, in that there was no single organisation or person in charge. Rather, the programme had joint sponsors from the acute trust and from the local authority – and a steering group made up of leaders from all partner organisations.
- **Visible leadership** from directors to frontline teams, showing a commitment to the programme and reinforcing a clear set of messages about outcomes. Senior leaders joined workshops and frontline design groups and acted as a face for communications.
- **Culture of outcomes-based performance** such that there was clarity in what a successful result would look like, and how outcomes would be measured. Leaders signed up to outcomes-based KPIs, and used those to hold operational teams to account across organisations for performance.
- **A strong programme identity**, not limited to any single organisation or professional group. The programme had dedicated communications resource, took a proactive approach to stakeholder engagement, and had a professionally designed brand identity.

Through strong leadership and management of the culture, the programme achieved:

- 4,650 more people avoiding admission every year through support from urgent community teams.
- 20% reduction in hospital discharges to bedded settings.
- 21% increase in effective reablement services.
- Increased the number of people going home from an intermediate care bed from 25% to 43%.
- 3,000 people per year better supported in the community to an independent long-term outcome.

"The success of the programme really demonstrates that we can make change across Essex and that we can break down organisational barriers."

Chief financial officer, NHS Trust

"I think the programme's biggest difference is its ambition. We haven't had many programmes that work across systems like this. I think that's the real uniqueness of the programme and it keeps people at the heart of what it's trying to do. It's not just about efficiency, it's about outcomes."

Director of adult social services, Local Authority

Closing remarks

This work has explored practical approaches to move from ambition to delivery of place-based partnership working, and achieve measurable improvements for people. The work has also explored some common barriers faced as systems begin to deliver new services and improved care at place.

Progressing integration across systems is one of the defining challenges faced by health and care services in England. Achieving true integration will take time, and sites will have their own approaches based on local needs and contexts, but starting with outcomes, systematically addressing barriers, and investing in developing an inclusive culture can have a timeless value.

> *"Can we pivot into a new place, where we create the future now, that gets rid of all the barriers? We could. No one is stopping us."*
>
> Chief executive, NHS Foundation Trust

CASE STUDY

The next phase of the integration journey in Lambeth

Health and care partners in Lambeth are beginning the next steps of further integration at place between primary, community and secondary care. Leaders from Guy's and St Thomas' NHS Foundation Trust, primary care services, and the South East London ICB are working together to develop a refreshed vision for neighbourhood working and better, more joined-up working with secondary care services.

Lambeth has strong foundations and ambitions for working better at place to support people closer to home, with acute and community services integrated under one leadership structure, community nursing aligned to neighbourhoods, integrated commissioning between the local authority and the NHS in Lambeth, and successful programmes, such as 'At Home' virtual wards, in operation.

However, faced with growing demand from an ageing and increasingly complex population, the partnership aims to develop closer working with primary care at neighbourhood level to better manage demand and improve support to people in the community. Partners in Lambeth have articulated an ambition to develop a 'perfect place', focused on improving health and care outcomes, and in line with many of the approaches explored in this programme.

They are in the early phases of this journey and have recently been working together to develop a vision for place and neighbourhood working anchored in key outcomes. In five years, the partnership aims for the experience at place to be:

- For residents: easy to access, proportionate, proactive, joined up, personal and caring.
- For staff: resilient, trusted and accountable, joined up, with clarity between roles, seamless communication, and consisting of the right workforce.

Engagement between partners has developed a set of outcomes for Lambeth to work towards as integrated neighbourhood working progresses. The table on the following page shows a high-level summary of the outcomes and measures of success being explored, and work is ongoing to clarify the evidence base and shape operational approaches to drive improvement in these areas.

Strategic outcome	Specific measure of success in future
Healthier residents leading to lower need for care	Improved vital five outcomes (blood pressure, obesity, mental health, smoking, alcohol) Fewer secondary admissions People more independent, less use of long-term care More effective use of primary care
Residents experience timely, seamless care	More use of self care Fewer steps on each pathway / referrals (right first time, make every contact count) Responsiveness - time need highlighted to diagnosis and resolution Patient reported consistency / clarity of communications
Staff feel valued, empowered and that they are making a difference to people	Staff retention and recruitment Staff engagement survey
Right use of resource, reduce over-medicalisation, appropriate levels of intervention	Reduce unnecessary tests / interventions / prescriptions

Leaders have reflected on challenges of measuring in silos, inconsistently, and are keen to work towards more joined up measurement of outcomes across Lambeth. They also reflected on the constraint of separate funding streams, and the need to keep overall system financial pressures in mind.

Strong foundations for partnership working in Lambeth have allowed leaders to reach alignment on what they need to achieve. There is a shared focus delivering the next phase of integrated working at place. Key priorities include refinement of target outcomes, and developing a shared clarity on, and commitment to, the key high-impact changes to service delivery. Looking ahead, the leadership group are looking to creative approaches – which may traverse traditional organisational boundaries – to improve the target outcomes and deliver truly seamless care for patients and communities.

"We have to balance our measures against our available resource – a measure of success is improving outcomes within the same or smaller budget."

GP

www.integrationatplace.org

NOVEMBER 2022

NHSProviders

Website: **www.nhsproviders.org**

Twitter: **@NHSProviders**

Contact: **Leo.Ewbank@nhsproviders.org**

NEWTON

Website: **www.newtoneurope.com**

Contact: **david.mcmullan@newtoneurope.com**