9 March 2021

Place the emphasis on outcomes

At the core of NHS England's Integration and Innovation white paper is the notion of 'place', perhaps the least described but arguably also the most complex aspect of integrated care.

It is at the level of place that health and care services will be organised under the proposals. Primary care, community health, mental health, social care and public health services, along with other government and voluntary sector services, will all fall under the remit of partnerships formed between primary care leaders, local authorities, Healthwatch, and community and mental health services, along with other local groups.

Those partnerships will work together on planning, generative and transformation programmes and tackling the wider determinants of inequalities. The primary care network features as the unit of delivery. Place is the locus for the adoption of local care pathways and regeneration. And for many people – although certainly not all – that will equate to local authority boundaries.

There are myriad questions raised by the proposals and most of them remain unanswered so far. The practical details of delegating functions and budgets are unclear. Enormous cultural hurdles stand in the way of genuine place-based collaboration between organisations of fundamentally different types. How do you seamlessly integrate bureaucracies with clinical bodies, political organisations, voluntary groups and private companies? Perhaps most importantly, how will the voices of citizens be heard and responded to by these complex new partnerships?

But at the heart of it all, we believe that the principles behind this place-based model are sound. We also believe that good governance will be key to its success.

Croydon case study

During one of GGI's The New NHS series of webinars, we heard first-hand insights from Mike Bell, Chair at Croydon Health Services NHS Trust, where integration has been at the heart of the way they work for some time.

Croydon started with some advantages. The NHS Trust was already coterminous with the borough and there were strong pre-existing relationships between the trust, the local council and primary care providers. The trust was also the home of community services as well as acute services.

All of these positive factors were already in place. But the trust and its partners had the foresight to create more. With new CCG leadership, the trust commissioned work to obtain a single version of the truth about financial and operational challenges in the system. This meant that for the first time there was a shared view of local challenges and opportunities. Added to this shared view was a shared vision around health inequalities.

The partners found ways to facilitate joint working and remove adversarial barriers. The trust and the CCG ensured that risk and control were both shared equally, which removed the bouncing of deficits traditionally done at the end of each financial year. As the relationship deepened, the partners began to address structural and governance issues. They started recruiting new executives as joint appointments between trust and CCG, effectively blurring the lines between commissioner and provider. Work is also underway to integrate further with the local authority.

Mike is convinced that the benefits of this partnership groundwork came to the fore during the coronavirus emergency. He pointed to the disproportionately low death rates in care homes across the borough. Croydon has 20% of London's care home beds but suffered just 7% of care home deaths during the pandemic. He sees this as a demonstration of the clear advantages of joined up working between the trust, community services, primary care and the local authority.

Honesty and courage

Another of our guest speakers, Catherine Thompson, Programme Director Improving Planned Care at West Yorkshire and Harrogate Health and Care Partnership ICS, offered further insights based on five years of integrated care.Catherine said it's about honesty in the collective decision-making process and not shirking difficult conversations to decide priorities for whole partnership. She pointed out that most places have similar challenges and goals; health inequalities exist everywhere and they're usually driven by the same factors, things like poor housing and air pollution.

For Catherine, the key was for the ICS to focus on agreeing what it wants to work on rather than getting mired in the detail of how it's going to be delivered at place. That should be done locally, because that's where the knowledge sits about what works best for each community.

There is a great deal that the NHS can and should do to get its house in order as we move further into the era of integrated care. Barriers must be broken down between acute and community, between community and primary care and between all of those and our mental health trusts.

These are all significant challenges but they also present significant opportunities. One way to realise these opportunities is to keep place near the top of the agenda – and GGI is determined to do exactly that.

Illuminations

- Place is the level to which most people feel most naturally aligned and where many local decisions should be made. Even if it is not fully prescribed in the upcoming legislation, place should be at the core of integrated care.
- If not at the level of place, where else do primary care networks connect to the new world of integrated care? Where else can GPs have their say? Place is where real decisions will be made.
- Not everywhere is like Croydon, where local government and health are coterminous. In many other areas the question must be faced of why the local authority should commit to the new model, only to see money that could be spent on its citizens going elsewhere. Partnerships must be built with local authority interests in mind or they will fail.

If you have any questions or comments about this briefing, please call us on 07732 681120 or email **advice@good-governance.org.uk**