Health Foundation submission: House of Commons Health and Social Care Committee inquiry into integrated care: organisations, partnerships and systems

13 March 2018

Section One: Health Foundation submission

The Health Foundation strongly supports the principles of taking a place-based approach to planning and delivering services, of better integrating and coordinating services around the needs of the patient, and of a stronger emphasis on prevention and health promotion, including supporting individuals to take an active role in managing their health. In recognising these important principles, Sustainability and Transformation Partnerships (STPs) have the potential to make an important contribution to improving health and social care in England.

The key challenge for STPs: achieving change on the ground

As set out in the *Five year forward view*, the key challenge the NHS faces is to reshape the way care is delivered in response to changing needs, including through better integration and prevention. New contractual and organisational forms, new payments systems, new governance and accountability frameworks – all of these can be important for creating the right incentives and removing barriers to change. But they do not, by themselves, change the way that care is delivered. Achieving that is much harder, requiring doctors, nurses and other staff on the ground to come together, develop new approaches and work together in different ways.

If changing the way that care is delivered requires those involved in delivering care to work in different ways, then the key question for any programme of reform should be: how is that going to happen? Historically, the NHS has had a tendency to invest in structural reforms with an assumption that the impact of these will filter down to influence the way that care is delivered on the ground, but too often this hasn't achieved the intended impact.

So a key litmus test for the move towards a place-based approach is: is there a clear vision and understanding for how STPs and related initiatives such as integrated care systems will lead to and facilitate changes in the way care is delivered? And is the space and support available for those on the ground who will need to plan and drive these changes to do so, alongside the essential business of continuing to deliver day-to-day patient care? If not, there is a risk that new plans, structures and systems are put in place but continue to support fragmented and unnecessarily acute-centred historic patterns of care.

Supporting those driving change on the ground

The hard work of changing the way care is delivered on the ground relies on those who lead and provide this care having the time, space, resources and skills to redesign individual processes and pathways.

We know from the work we fund to support service improvement in the NHS that this can be a significant endeavour. Relationships have to be built across organisational boundaries. New services have to be co-designed with patients, families and staff. Consensus has to be reached on plans for change. New roles or teams may have to be created, such as multi-disciplinary teams. Changes need to be tested, evaluated and revised – which in turn may require developing local analytical or evaluation capacity where this does not already exist. Even when ideas have been successfully tested elsewhere, substantial work may still be needed to adapt them to local context. And all while continuing the more immediate task of delivering existing services within a very pressured financial and staffing environment within both health and social care.

Given the hard work required to change the way care is delivered on the ground, it is critical that NHS leaders and bodies support those who will need to lead and implement these kinds of changes – both within specific programmes such as STPs, and more generally as part of the wider mission of improving healthcare. The complexity of change involved means that it can't be driven centrally; rather, this is about how the 'centre' can enable those who work in the system to drive change themselves.

Successfully delivering change may well require resources – for example, to establish project-management teams, backfill staff positions or for initial double running costs. It also takes time; for example, our recent study[1] of progress made by the new care models vanguard sites found that work had already been going on to establish new models of care for between 2-10 years before the new care models programme started.

It also requires investing in the development of staff to ensure they have the right skills to make change, such as leadership skills, improvement skills and change-management skills. There are important initiatives on which to build here, such as NHS Improvement's *Developing People, Improving Care* strategy. This kind of capability-building work is vital but often gets less attention and resources than more centrally-led change programmes.

It is welcome that the written submission from NHS England and NHS Improvement to this inquiry recognises that identifying clinical leaders and wider staff to drive change on the

[1] http://www.health.org.uk/publication/some-assembly-required

ground "*are central challenges for every STP*" and that "*many [clinicians] tell us the pressures of their day job prevent them from fully engaging in transformational change*". If the STP programme is to live up to its potential then it is essential that these issues are given the priority they deserve.

The challenge of service transformation and whole-system change: evidence from recent Health Foundation research

These perspectives on how change happens are reflected in a number of recent Health Foundation research reports.

Our report on learning from the new care models programme[2] found that sites did not describe changes to organisational and governance structures as the initial catalysts for wider change, nor did they rush to create new organisational forms or contractual arrangements. Instead, they often began their work by identifying clinicians and teams who already had ideas and were willing to lead change locally.

Often building on years of work before the programme, they used informal partnerships to develop collaborative relationships and test new cross-organisational pathways; formal changes to governance and organisational arrangements were then considered later, based on learning from the process of care redesign about what was needed to remove barriers and align incentives. The report warned that: "*focusing on restructuring organisations and tendering new contracts from the outset is understandable given the current pressures to deliver improvement at pace. Yet this research suggests this approach may neglect the groundwork required to make meaningful changes to the way care is delivered. The core aims could become distorted – from 'how can we improve the care for patients in this area?' to 'how can this area become a PACS, MCP or ACS quickly?'*".

Part of the hard work of making changes across boundaries was moving from the initial enthusiasm to creating clear objectives across organisations. Many sites began with an initial vision created by a small group of often senior leaders. They then brought together staff and patients to discuss and agree clear objectives. This began with working through a shared understanding of the problems to be solved – a crucial factor in cross-team improvement work.

Bringing together teams from across organisations in this way was a time-intensive process. Finding dedicated time for stakeholders to develop new relationships and nurture established ones was essential – the process sought to bring the tensions and preconceptions of individuals, many of whom had a history of working alongside each other, to the surface. Some sites initially used external facilitation, and some continued to use it throughout the programme.

Vanguard sites were also required to use programme theory – specifically logic models – to work through and challenge assumptions around how activities will achieve results. A logic model is a diagram or visual map of the relationship between a programme's resources, activities and intended results; it also identifies the theory or assumptions underpinning the design of a programme. This visual representation is designed to fit on one side of a page. But given the complexity of the interventions, sites often used multiple interrelated logic models for different areas of the programme to capture the varying levels of detail.

Sites used facilitated workshops to design these models. They generally felt that coming together in workshops and creating the logic models was positive for the design of their

[2] http://www.health.org.uk/publication/some-assembly-required

interventions locally. It supported them to think through and discuss links between planned activities and outputs, and draw out risks and enabling factors. In some cases, it altered the course of action.

Some sites expressed frustration with the compressed timetable set by the national programme for creating logic models. They felt it limited their ability to effectively bring partners together. Those seeking to use logic models should, therefore, carefully consider the time and people required to do this in a meaningful way at the outset, to avoid the process becoming a box-ticking exercise.

The vanguards also benefitted from funding for evaluation. Multiple changes were taking place within the vanguard sites, with many of these changes starting from different stages of development, at different points in time. Some sites focused on running services in parallel while others introduced outright changes to existing services. This was often dependent on the level of confidence in the model and engagement of the clinical teams and patient groups, especially where the work had been done in other areas locally prior to the programme. Due to the complexity of the new care models, there was a strong focus on understanding what was happening, evaluating and measuring impact, and building on the initial work as part of the logic model process. Sites described the importance of using this information to help shape their plans as they progressed.

Ascertaining clear cause and effect in these complex systems was not a simple task. This did not undermine the role of evaluation, but rather emphasised the need for teams to continually challenge themselves and to look for new forms of information to understand what is happening. Lessons from research into safety suggest that this should also involve seeking uncomfortable and challenging information to alert teams to blind spots.

Our recent report on NHS provider partnerships[3] also highlighted some similar issues that are likely to be relevant to STPs.

The importance of senior and clinical leaders in achieving successful change is already well established, but leading and managing partnerships between providers adds a further dimension of complexity. Engagement and influence has to cross organisational and service boundaries and staff members not only need to have faith in their own leaders but also in those of their partner organisations. Managing across partners also provides additional complexity due to different financial processes, internal accountabilities and underlying cultures. These complexities must be recognised to enable logistical issues to be considered and addressed.

Whatever the scale of the partnership, there will always be individuals whose personal collaboration will be key to success. Individual trust between these people will be important and previous positive interaction can provide a foundation for collaboration, but such relationships will not always be in place. Partnerships brokered by an external body may not benefit from a good cultural fit. In such cases, developing a productive partnership will require considerable and sustained effort across all levels of each partner organisation and may take years rather than months. A partnership involving several organisations will mean that multiple cultures need to be understood and responded to.

The challenges of working across organisational boundaries are also demonstrated in the Health Foundation's recent report on improving whole-system flow[4]. The report describes the key enablers of whole-system working, arguing it is critical to attend to the cultural

[3] http://www.health.org.uk/publication/partnerships-improvement-ingredients-success
[4] http://www.health.org.uk/publication/challenge-and-potential-whole-system-flow

enablers, such as leadership and staff engagement, as well as the structural enablers, such as contractual mechanisms and information governance.

This work highlights how attempts to improve services across an entire local health economy need to be underpinned by an effective infrastructure for collaboration. The report argues that at present the barriers to effective collaboration across organisational boundaries may outweigh the enablers. Part of the problem is that emerging partnerships are often unable to dedicate sufficient time and resources to make the most of their collaboration. Participants might hardly get the chance to get to know each other before embarking on a series of formal meetings and negotiations – even though informal conversations are often crucial in building strong trusting relationships and in surfacing concerns and potential obstacles at an early stage.

Ensuring that participants have the necessary skills to maximise the impact of any collaboration is also crucial. These skills include the ability to make connections between your own work programmes and strategic priorities and those of others; a willingness to operate in networks that do not have clear rules; and a capacity to identify and strengthen shared values. However, these attributes have not always been given the priority they deserve in the training and recruitment practices of health and social care organisations.

Looking beyond short-term demand management

One risk for STPs is that they become viewed primarily as vehicles for demand management, particularly for reducing the growth in emergency hospital attendances and admissions. This could make it harder to engage both patients and the health and social care workforce in change, who may well value other dimensions of quality, such as improved outcomes and patient experience.

Here, it is also important to bear in mind the incomplete evidence base for achieving reductions in emergency attendances and admissions. The evidence about which combinations of interventions can achieve such reductions is still emerging and far from straightforward, as the recent Improvement Analytics Unit[5] (a partnership between NHS England and the Health Foundation) evaluations of new care models in Rushcliffe[6] and Northumberland[7] demonstrate. Moreover, the incomplete evidence base necessitates experimentation and evaluation over the long-term, which recommends against 'performance managing' STPs for short-term reductions in acute demand.

Ensuring national programmes are aligned and support local action

The context in which STPs have to develop and make progress is hugely influenced by national priorities, programmes, oversight and regulation. These can impose significant demands on local systems and have a 'make or break' effect on local partnerships and initiatives. In the Health Foundation's 2015 report Constructive Comfort[8] we argued for an annual exercise to understand the 'collective weight' of national policy action on local health economies and to weigh up the costs and benefits.

A particular challenge arises when, as in the current environment, there are multiple place-based programmes and initiatives. Whether or not such initiatives reinforce or conflict with one another can have a significant impact on a local health economy's ability to reshape

[5] http://www.health.org.uk/programmes/projects/improvement-analytics-unit
[6] http://www.health.org.uk/publication/impact-enhanced-support-rushcliffe
[7] http://www.health.org.uk/publication/impact-redesigning-urgent-emergency-care-northumberland
[8] http://www.health.org.uk/publication/constructive-comfort-accelerating-change-nhs

services. Alignment between national policies and programmes can be particularly important for supporting the local leadership required to drive change across health and social care.

In this context, it is therefore important to understand whether and how national bodies are coordinating their activities, and in particular what, if anything, they are doing to understand the overall impact of these activities from an STP or other local perspective.

The challenge of replicating success at scale

Change as complex as the kind of service transformation required from STPs will be highly context-specific, rooted in the particular circumstances and challenges each local health economy faces. While new ideas and care models can be transferable across different locations, each is likely to require significant adaptation to work in the specific context in which it is implemented. This means it would be a mistake to assume that once an idea has been successfully demonstrated in one location then the hard work has been done and everyone else can easily and quickly adopt the same approach. As highlighted by recent Health Foundation research on the challenges of spreading complex healthcare interventions[9], those adopting ideas and practices from elsewhere will often need substantial time, resources and creativity to translate the idea into their own setting and make it work.

A related consideration is that STPs have started from very different positions and some areas are substantially better placed to bring about change than others. This variable capability and readiness has important consequences for trying to replicate success at scale, and it is clear that some areas may need more support than others to implement the same types of change.

Very often national programmes focus resources on a few pilots who can demonstrate success and then assume that the same changes can be rolled out to everyone else quickly and with fewer resources. But the considerations above suggest that 'adopters' and 'followers' within national programmes may need just as much, if not more, support to implement new care models as 'innovators', 'vanguards' and 'pioneers' (many of whom were developing their changes prior to the initiation of national programmes).

So it is important to consider the appropriate distribution of resources for supporting the development of STPs and the spread of successful practices. In terms of those areas requiring significant assistance, it will also be important to learn from the experience of other national efforts to support challenged health economies, such as the Success Regime.

Section two: questions for consideration

1. What is the theory of change underpinning STPs, ie how will bringing together local service leaders lead to transformational changes to the delivery of health and care services?
2. How will the success of individual STPs ultimately be judged, beyond the most immediate priorities to reduce demand for emergency and elective hospital care and balancing budgets?
3. What are national bodies doing to ensure STPs remain focused on the question of 'how can we improve care?' rather than 'how can we become an ICS?'? What lessons can be learnt from the selective rollout of past initiatives that were subsequently rolled out to the whole country, eg foundation trust status and integrated care pioneers?

[9] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.1161

4. What support is available to ensure that those on the ground who will need to lead and implement service change have the resources, time, space and skills to do so, alongside the essential business of continuing to deliver day-to-day patient care?
5. What are the national bodies doing to engage with STPs to understand the overall impact of the range of national plans and activities relating to place-based planning, service transformation and improvement, to ensure that these are as coherent and as supportive of change as possible?
6. What is the right balance between supporting those areas forging ahead to become the first ICSs against supporting those areas who have further to go to be ready for change – and who will still have substantial work to do to translate lessons from the first ICSs into their own specific contexts? Are there lessons to be learnt here from the impact of the Success Regime?

Section three: about the Health Foundation

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

We make links between the knowledge we gain from working with those delivering health and health care and our research and analysis. Our aspiration is to create a virtuous circle, using what we know works on the ground to inform effective policymaking and vice versa.

We believe good health and health care are key to a flourishing society. Through sharing what we learn, collaborating with others and building people's skills and knowledge, we aim to make a difference and contribute to a healthier population.

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