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Creating Integrated Neighbourhood Teams

Learning from Experience

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Introduction

The new government and Lord Darzi's review both set the direction of travel towards a neighbourhood National Health Service (NHS). They also stress the long-standing failed ambition to shift resources and focus from secondary care to community and primary care and to boost prevention. This is very much in line with the vision in the Fuller Stocktake and progress towards this was already underway prior to the election.

There is a lot to do to develop this vision and, at the same time, address serious concerns about general practice and its sustainability. The idea of what a successful Integrated Neighbourhood Team (INT) will look like is still emerging. However, previous experience developing integrated care and the Vanguard programme highlights some serious weaknesses in the approach to change in this area. Many attempts to create different types of integrated care have had disappointing results but there is an opportunity to do things differently this time.

The National Association of Primary Care (NAPC) has a long history of being at the forefront of thinking about the future of primary care and some key elements of current policy reflect ideas that it has developed. This paper brings together NAPC's experience of how to make INTs work and how to manage the challenging process of change and is designed to provide a guide to creating a neighbourhood health service.

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Where we are now

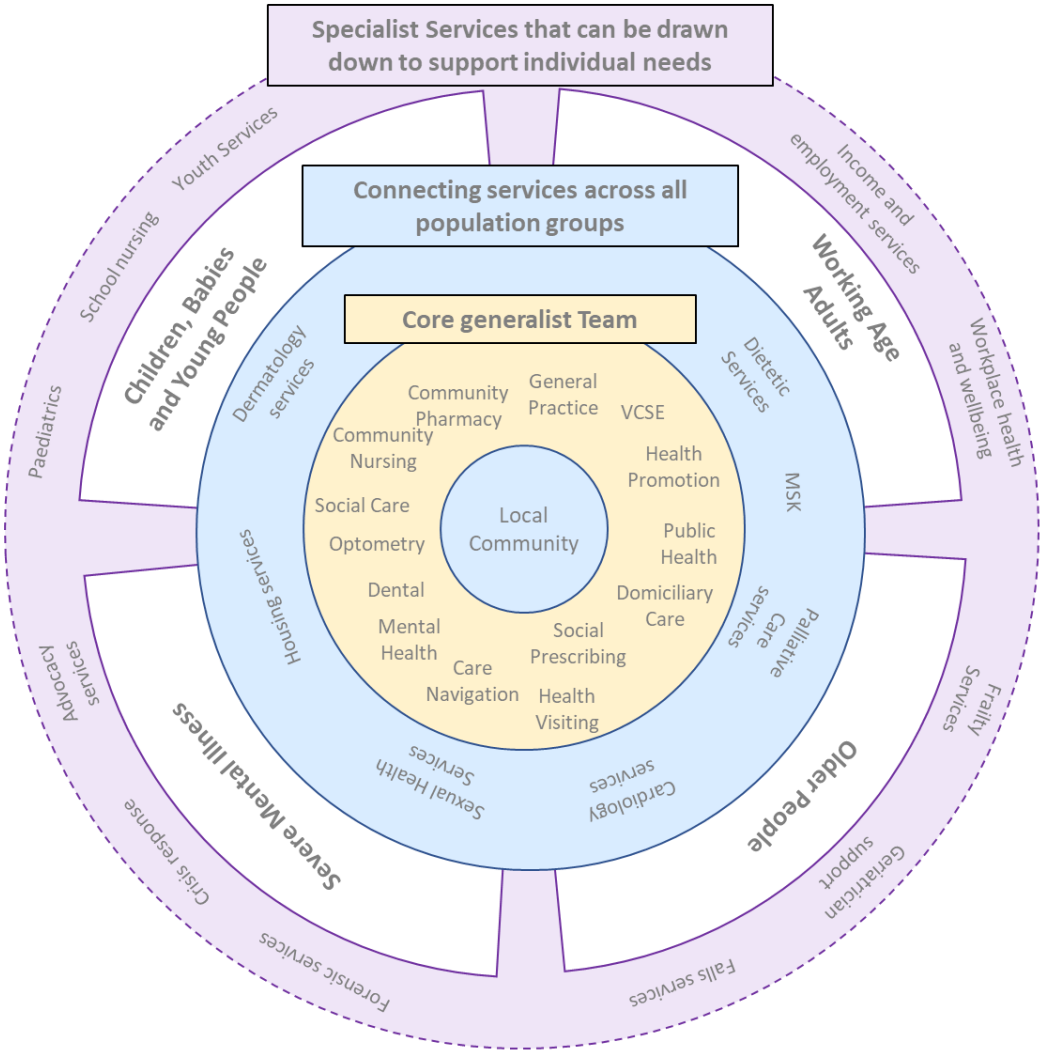
Integrated Neighbourhood Teams are a key part of plans for improving outcomes, prevention, shifting resources towards primary and community care and tackling inequalities. There is an emerging consensus about their key elements with, at its core, a team bringing together functions that have a high level of interaction with the local population and each other. This generally includes:

- General Practice (GP) practice staff and other primary care staff
- Community nursing, health visiting and AHPs
- Mental health staff
- Social care staff, domiciliary care
- Children's services
- Community pharmacy, dentistry and optometry
- Input from Voluntary, Community and Social Enterprise (VCSE)
- Input from other agencies

The idea of a team of teams is often used to describe this. The rationalisation of multiple access points and replacing complex referral and administrative systems that create barriers to care with more rapid communication and team-based care are a common feature of the vision. In some cases, this might involve bringing admin teams together and having a clear single point of coordination.

These teams will be able to draw on specialist expertise from other professionals where a larger population footprint makes sense, for example, palliative care, housing, Musculoskeletal health (MSK), dietetics, hospital specialists etc. The same principle of reducing referral or multiple single points of access applies here.

An example of what this might look like from North West London (NWL), which mirrors thinking in some other Integrated Care Boards (ICBs) is shown below:



*Specialist services are indicative and not exhaustive. These teams will flex and respond to the needs of individuals and groups within our populations.

Figure 1: Specialist Services that can be drawn down to support individual needs

The definition of neighbourhood has caused some debate but it is clear that it must be meaningful to the people who live there and who it represents. This can create some issues for statutory services and Primary Care Networks (PCNs) in some instances, but some degree of messiness is often unavoidable, and some compromises will be necessary. Some elements of detailed design remain to be worked through, and these will need to be resolved as the model develops through experiment and evolution. While there will be differences between areas over time these should be reflective of different population needs and geography rather than the vagaries of history.

The workload and economic pressures in general practice are a serious concern and need urgent attention. The approach to developing INTs therefore should explicitly seek to address this and make quick progress to create capacity, make working in primary care more attractive as well as creating time to plan and develop changes in how the teams work for effectively.

These changes will positively affect health status, staff and patient experience and make a significant contribution to achieving the goals set by the government. NAPC analysis suggests that they will improve the cost effectiveness and efficiency of NHS spending and reduce the future funding requirement driven by poor health status and demographic change.

What could we aim to achieve?

Most savings will be non-cash releasing, but this is not an issue as what is required is capacity and health improvement.

- Improvements in staff absence (14%), productivity (3%) and turnover (10%) from changes in staff engagement
- A 7% reduction in the cost of care for high intensity patients
- Reduction in GP demand (6%), outpatients (6%), ED attendances (12%) and bed days (14%)

In the longer term there will be savings from switching from a highly interventionist medical model to an approach based on what people value in areas such as end of life care and some aspects of chronic disease management. Nevertheless, the lesson is that the NHS habit of offering unfeasibly large and rapid cash savings to appease the Treasury should be avoided.

Making change happen

A different approach to developing the model and managing change is needed from the top-down, structural, uniform and directive approach that has usually been adopted. We start from the premise that successful change and the creation of a person-centred health and care system should start with a focus on the staff. We contend that it is not possible to focus on the patient without **empowered staff engaged around a shared purpose.** When staff have the right skills including quality improvement methods and **high-quality leadership and effective operational management,** they will be able to develop the second pillar of change which is the **development of integrated care** and the deployment of population health management tools and the **development of more effective models** for delivering care, particularly prevention. Effective integrated teams with a clear neighbourhood focus provide the means to drive the third and fourth elements of this approach the **active involvement of citizens and patients** and the **engagement of the wider community.**

The methods to do all of this are well understood and have been successfully applied but they require **experimentation, adaptation and learning from experience** to fit the local context. This needs time and investment in supporting staff and leaders in redesigning elements of their system and making changes. They will also need delegated budgets and at a system level there may be some difficult resource allocation decisions to be made. Both place and ICB levels will have an important role in support the INTs and facilitating change.

Whether policy makers and managers have the patience to wait for delivery, the humility to trust the staff to deliver or the courage to invest in different approaches from what they have done before is open to debate. If they don't, then we can safely predict that this latest round of reform will be yet another disappointment at best and failure at worst.

Start with staff

Most attempts to develop integrated care models have started by working on systems, processes, information flows, governance and other technical components. These are important but are not the right place to start and this has meant that insufficient weight has been given to engaging staff or the importance of effective relationships within the team. Health and care systems are highly complex staff have a key role in dealing with problems and fragmentation in ways that are difficult to replicate just by designing better systems and processes.

There has tended to be an assumption that staff in teams and services know each other and have a good understanding of their respective roles and capabilities that will allow them to do this. Very often this is not the case and especially not as INTs will be bringing together GP practice, wider primary care, social care, community and a range other staff including many people from other parts of the system into new teams. These staff will have often worked separately and been relatively loosely connected. The nature of their work means that much of their time is spent in one-to-one consultation with patients or contact with clients rather

than with colleagues. This a particular issue with people working in domiciliary care. As a result, strong connections will take time to develop and the way that staff have been deployed and moved around has often undermined them. They may even have different conceptions about the nature of their work and its underlying values and approach.

Work by Michael West(1) and others(2) shows a clear link to effective team work and performance. However, too often in healthcare people work in 'pseudo-teams', i.e. they are in work groups which lack vital elements. West identifies several elements of high functioning teams:

- A limited number of clear objectives
- Clear roles and responsibilities
- High quality and frequent communication and interdependent working
- Reflectiveness – the team comes together regularly to reflect on their practice, how they work as a team, their relationship with other teams and how these can be improved
- Conflict is identified and resolved

This helps to create an environment of 'psychological safety'(3) in which staff can voice concerns, try out ideas and talk about things that have not gone well. This is also closely associated with high levels of team effectiveness, innovation, productivity and higher quality care(4). In addition, mentoring, peer support and feedback on progress are needed to help with the continued development of the team and sustaining progress(2).

All of this needs work and in most cases will not emerge on its own. An overly rapid move to throw different staff together without work to develop the team will tend to create pseudo-teams of people 'practising together, alone' which can make things worse and the model will fail. So, rather than immediately starting on the design of systems and processes there is work to be done to build teams, create a sense of engagement with the work, develop trust and mutual understanding of roles, the objectives and the shared barriers. Pausing to ensure that staff have roles that provide appropriate levels of autonomy, that they feel that they have mastery of their role and that they feel connected and purposeful is also important.(5)

Measuring the culture or climate of teams periodically is essential and provides the team and its leadership with important information about how the team is functioning and if any corrective action is required. NAPC use a simple measure of staff engagement to do this based on their willingness to recommend the team as a place to work to treat a friend or relative. Michael West's work and similar research outside health shows a clear link between this measure and organisational performance.

Small but important changes that improve patient care or staff experience can be implemented and quickly create trust and confidence as well as providing a way of building connections. To do this high-quality visible leadership is obviously important but the wider

development of skills in improvement, collaboration and management across the whole team is equally vital. ICBs need to invest in the development of improvement expertise in INT staff.

KEY MESSAGES

- Starting with the staff will greatly increase the probability of success, increase innovation, lay the foundations for further improvement and improve motivation and retention
- Work is needed to ensure that there are real teams with a shared sense of purpose, clear goals and other aspects of effective teamworking.
- Staff will need time to get to know each other
- Measurement of staff engagement and working to develop this by well-designed interventions is essential
- Skilled facilitation is required to make the most of this

Develop integrated care

Integration has multiple definitions and it is more helpful to focus on the key elements that really make a difference to patients - as in this definition by Schaef et al.(6)

"*A form of organisation that contains a wide range of services (above all, primary medical care) and by coordinating them attempts to produce the continuities of care (cross-sectional, longitudinal, flexible, relational, and informational) through pooling the funds and resources for the different areas of its work, enabling it to provide whichever services it judges the most suited to the patient and most economical overall, irrespective of the received division of labour and without concern for the internal distribution of costs*."

NAPC's work draws similar lessons to that in the literature about the common principles that need to be built into the work of local teams.

Understand need, demand and risk

Creating a sustainable team and meeting patients' aspirations for access will require a deep understanding of the population, the nature of demand and what people think they need to help them manage their health more effectively. This can help to plan capacity and indicate how services need to change to match demand. In many cases the demand and capacity analysis will reveal a gap causing problems with waiting. It is likely to reveal that although there is a large number of staff in the INT and supporting services, this capacity is misaligned to demand. Over time, a redesign of how work is done and staff are deployed will be needed but this will be dependent on high quality analysis of needs and demand.

A key step is to identify segments of the population of individuals and understand their needs and levels of risk. Segments based on similar needs are a more useful approach than using risk stratification which may create groups of people who have disparate needs. Segmentation uses local data from primary care, prescribing, pathology results, community nursing and other systems, including if possible social care and socio-economic data. Bringing in situational knowledge from team members means that sections of the community, particular households or small areas with a high level of need can be identified even if they do not show up in the data. These may be some of the people for whom the biggest difference can be made and an important step will be to take action to reach out and find them.

There are a number of tools to support INTs in analysing demand, need, risk and capacity and they will need help with applying these. Analytical support to INTs will be a critical part of many of the elements of developing their work set out below.

Develop a proactive approach

While those people with the highest risks may not benefit a lot from additional input, much more can be done to make a difference to people in lower risks groups and those who have not yet interacted with the health system much but are likely to have lifestyle and other factors that mean they are likely to develop problems in the next few years. These people can benefit from proactive approaches to help them make improvements in self-care and life-style related risks. Other proactive interventions to improve patient activation, to support carers and work with communities will also pay dividends – see below.

A proactive approach with the segments of the population who have multimorbidity, medium levels of complexity or a dominant major chronic condition can have a rapid impact on the demand for GP appointments and emergency department use and in some cases admission to hospital.

This is not about just dealing with the tip of the iceberg but understanding the totality of need and where there is the most potential for useful impact.

Simplify processes

Bringing together different staff groups into a team focused on the neighbourhood is an opportunity to improve how staff work and to rationalise much of the paperwork and referral processes that have grown up. There has been a multiplication of different teams that fragment care and deal with its components rather than the whole patient. They also make it difficult to know where the patient should be referred. They have spawned complex triage and assessment processes, and a lot of time is wasted completing long forms, not least because too often the answer to a request for help is “no”. The problem is that many people who are screened out by referral criteria will return, probably in a worse state and in the meantime will have been back to their GP, visited the Emergency Department (ED) and used other services. The use of these processes to manage workload looks attractive but is counterproductive.

A multidisciplinary team of staff who understand each other’s roles and where the focus is on the patient and the local population and its needs rather than on the execution of tasks or the management of a caseload can shortcut much of complexity that has been created. Alisons Leary’s critique of the ‘taskification’ of roles and a focus on competences rather than professional judgement in the NHS is that by diluting skill mix the result has often been higher costs, poorer quality and less rewarding work.(7) Better trained and more skilled staff are more likely to understand the holistic needs of the patient and how to mobilise support from the rest of the team.

Standardisation of processes within and between organisations and ensuring that staff understand the operating procedures is important but is not a substitute for having the

training and ability to exercise professional judgement, talk to colleagues and solve problems.

The INT admin team can provide the much of the necessary coordination within the team and support GPs and other clinicians in doing this. This may reduce the need for staff whose main job is care coordination.

A rationalisation of the services provided on a larger footprint than the INT will also be helpful and again can release resources through reductions in complexity, administration and having a simplified entry routes and one single point of access. A simplification of workflows and the implementation of easy-to-use shared care templates can facilitate some of this and redirect staff time from administration to patient care.

It is also important that larger providers are not asked to have multiple different ways of relating to different INTs for pathways that can be standardised.

Equip staff to deal with the work

Generalist skills are undervalued in healthcare but in this context, they are particularly essential. A psycho-social approach alongside excellent biomedical skills is also important. As noted above a focus on roles rather than skills in recent policy has not been ideal and as INTs develop a plan for ensuring that they have the right skills will be needed. This may need to also examine the need for helping staff work with new digital tools.

The policy focus on multidisciplinary teams has perhaps obscured the fact that a majority of patients needing care will still see a single clinician and have their issue resolved without little or no input from the wider team. This means that we need to ensure that in the consulting room, clinic or patient's home the professionals are empowered, trained and equipped to deal with the majority of what they are asked to do, but that help and support is easily at hand. Huddles, team meetings and other opportunities to exchange information and build connections are an important aspect of developing team effectiveness and leaders should ensure staff have the time to do these. Formal multidisciplinary team (MDT) meetings are expensive and time consuming and so need to be used discerningly as they do not appear to add value for some types of patients.(8)

In many cases chronic disease, mild to moderate frailty will be identified as being the areas with the most significant opportunities for improvement. For working age adults. anxiety, depression and some non-medical issues such as loneliness and the impact of deprivation are likely to also be significant drivers of demand. Ensuring that staff across the team understand how these issues are managed and their role, and that of others, in supporting this is an important part of the model. Staff need training and appropriate ways to ensure people reach the right service as well as knowing what they can do within their range of

competencies and when to ask for help.

Providing the right infrastructure to support staff in their work is essential. The development of the Additional Roles Reimbursement Scheme (ARRS) policy paid inadequate attention to questions such as where these staff would sit and what equipment they would need. Digital infrastructure is also important and access to modern digital tools, the ability to share data across the system and obstacles to the use of data for population health remain major problems that are holding back progress. INTs development needs to be supported by a plan for physical and digital infrastructure including easy electronic dialogue between professionals that is better integrated into other systems than WhatsApp. Investment in the operational management expertise to support this is going to be vital.

Enlist the hospital specialists

Hospital specialists have often been a missing element in much of the discussion of integration, in spite of the fact that they have a great deal to offer. A population of 50,000 generates significant outpatient activity. The table below shows the weekly activity for a sample of specialties.[1]

Table 1: Patients per week for a 50k population

Specialty	First appointment	Total
Paediatrics	19	50
Cardiology	28	62
Dermatology	22	58
Respiratory	12	36
Neurology	9	26
ENT	23	49

Geriatric medicine records fewer outpatient visits but consultants also provide a lot of support and advice as well as managing the acute and rehabilitation phase of patients' care.

This represents a substantial amount of clinical time. The question (posed by Professor Bob Klaber) is whether 1:1 clinic consultations are always the best use of this specialised expertise and, where they are, what proportion need to be face to face. A different way of connecting specialists to the INT could make a major difference. Rather than anonymous advice and guidance models the aim is for an on-going relationship that breaks down the barriers and allows the specialists to appreciate the skills of the primary care team and understand the context of the patients and for GPs to have options other than referral and to acquire new knowledge. Beyond this, specialists could provide insights to population

[1] Based on a 50 week year. 2023/24 Data NHS Digital Hospital Outpatient Activity 2023-24 - NHS England Digital

health management by working to identify gaps between the expected and actual levels of disease, advising and advocating for prevention and working with the social prescribing and other INT services to support patients in improving self-care. They can also benefit from learning more about the context of their patients and how risk in managed in primary care.

KEY MESSAGES

- INTs will need to have a deep understanding of the population, the nature of demand and how best to address it
- Finding higher risk people who are not getting help will be very important
- Developing proactive preventative services and to improve the management of non-communicable diseases and help people to improve their self-care requires more emphasis
- Simplifying processes, radically reducing the use of referral, forms and hand-offs will streamline care, release resources and lift a lot of administrative burden
- Develop a well-trained generalist staff and invest in additional skills and understanding of the system
- Infrastructure – both physical and digital needs a plan
- Hospital specialists need to be seen as an important partner in developing better population care and new models for working with them need to be developed

Leadership and management

The work of engaging staff, integrating teams, managing change and redesigning processes is difficult but worthwhile work. INTs will need strong multidisciplinary leadership teams, and these will need support to develop.

NAPC Faculty's experience from developing Boards and senior system leadership teams is built on a handful of principles, honed over the years:

1. The first step is to **build a foundation of trust based on vulnerability**. Only by doing this first, can leadership teams move on to have healthy dialogue about the issues that really matter.
2. Leadership teams need to **understand themselves and each other** – self-knowledge is key to developing emotional intelligence and leading themselves, their teams and the INTs effectively.
3. Leaders need to learn to **assume that all behaviours have their roots in good intentions** – and develop the habit of being curious about those good intentions in each other, and in those outside the Team.
4. The **systems (teams, organisations, communities, institutions) are an unconscious and powerful driver of all our behaviours** – it is important to help leadership teams notice the impact that the system has on them, and those around them. This helps to develop empathy and depersonalise issues so that they can find common ground on which to move forward.
5. **An appreciative approach** – more progress can be made by building on the existing strengths, capabilities and potential in teams. This generates energy and spins the flywheel of momentum. A focus on weaknesses can often lead to teams getting stuck.

This compassionate approach helps build confidence and honesty in leadership teams that: see the lessons in failure rather than blame; listen to staff; get curious about issues, and mine them until resolved; aren't afraid to have difficult conversations; that hold each other to account (without taking it personally) in the interests of the collective purpose of the Team.

Leadership is important but the NHS consistently undervalues administration and management and the role these have in operating, designing and continuously improving basic systems and processes. Problems with these are a significant barrier to the ambitions for integration but are also a significant source of frustration to staff and patients. Admin staff need to be part of the team and equipped with the same improvement skills as other team members. Much more attention needs to be given to developing skills and capacity in

these roles as well as to the leadership of the change.

At the place and system level there will be a number of important functions needed to provide support to the INTs including analytics, coordination between different services, help to manage the interface between larger providers and local teams and provide oversight on the management of delegated budgets. There are a number of possible ways of organising this and the role is currently not fully understood or developed. Systems need to dedicate time to working out what works best in their context.

Engaged citizens and patients

To be really effective INTs will need to engage with their population in different ways. Where time allows in the consultation professionals can use conversations about prevention, brief interventions and motivational interviewing and these are a powerful approach. However, the time available in the average consultation generally makes doing this a challenge and the number of people who need to be reached is much greater than the resources available if this is the main method.

Using the insights about the population and the segments where there are higher levels or need and opportunities for impact, INTs will need to develop different approaches to activate patients and citizens and tailor its approach in ways that work for them. Often this means delivering services to people in their homes rather than expecting them to come to the services. Four approaches, supported by research and experience in the field offer new and more effective ways to do this.

Enabling and measuring engagement

The academic literature uses the term patient activation to mean that patients have knowledge, skills and confidence to manage their health. Engagement and empowerment of this type is associated with improvements in health, experience of care and self-management.(9) Using a knowledge of the patient's activation level to tailor the intervention are most effective and patients who have the lowest level tend to increase the most.(10) The measure also is a good way for INTs to track progress in their work.

The NHS has bought licences for the comprehensive measurement tool developed by Judith Hibbard, but NAPC propose a simpler approach that can also be easily used opportunistically with patients.

Figure 2: If We Improve Patient Activation What Could This Achieve

Working with groups

Patients can be helped to understand and manage their condition, change aspects of their lifestyle through working in groups to supplement their 1:1 work with health professionals. Group consultations have been used for annual reviews for patient with asthma or diabetes and allow more time than the traditional face to face consultation so that more issues can be explored. The sessions are led by a facilitator, who could be any member of the practice team, with medical or therapeutic input from the appropriate clinicians or allied health professionals.(11) These work well online and supplementing them with an appropriate app improves the results even more. Staff may need to develop their skills to work in this way. Beyond this group work on aspects of self-management, weight, diet, mental health are also highly effective and can be run on a rolling basis. These can be aimed at people who have signs of impending problems. When the wider community is engaged there are even more possibilities – see below.

Digital engagement

It will be important that the functionality of the NHS App is developed to support a wide range of interactions between patients and the INT and its constituent parts. A suite of associated apps to support engagement in group consultation and group work, health promotion and digital tools to help people self-manage and support life-style improvement through reinforcement and behavioural nudges will also be an important part of the model in the future.

Community Health and Wellbeing Workers (CHWWs)

In some communities the deployment of CHWWs attached to practices is a highly effective way of delivering prevention and support to patients and families. A model of CHWWs who work with households to provide a link to health services, identify issues, help with prevention and health promotion. The effectiveness of this in improving health, particularly for people with whom the NHS has difficulty engaging is remarkable.(12) It is a particularly helpful intervention in communities where there is little social capital or existing community action.

There might be opportunities to work with domiciliary care workers in this area and bring them into the wider team in new ways.

KEY MESSAGES

- Finding ways to work with more people through digital and group work will be essential to meet the aspirations for improved prevention and self-management
- there is good evidence that these approaches make a significant difference to patients' health and can impact on demand for health services

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Engaging communities

The local focus of integrated care teams and the engagement of local government in place-based partnerships means that there is an opportunity to work with communities in new and more effective ways. Many of the determinants of poor health are outside the reach of the NHS and other statutory services(13) and INTs need to be working with local communities to support the develop of community based action that can help to create social capital – the vital connections and relationships that create cohesion and resilience in communities.

When communities come together to identify their issues and design solutions to issues that affect their health and wellbeing, local environment, employment and other areas that matter to them they can make an enormous difference. A recent report from Local Trust and NHS Confederation echoes other research in this area to make a strong case for investment in hyper-local community action that empowers communities and helps them to help themselves.(14) Relatively small amounts of investment in management, somewhere to meet an funding to get things moving can really help. This needs to be provided in ways that are appropriate to schemes that are often small and run by the VCSE and have a different culture from statutory services.

INTs can support this, but the leadership has to come from the community itself. The activities and groups that local initiatives produce can also support the INT by providing resources to help patients and where the answer to their problems is non-medical, e.g. help and advice on fuel or food poverty, loneliness, etc. this can also help by providing a link to the VCSE sector and help to coordinate requests for help with social prescribing.

KEY MESSAGES

- Mobilising the assets that already exist in most communities will be essential to address the wider determinants of health
- INTs are a key partner in working with community initiatives
- local authorities and ICB place partnerships need a locally focused approach to nurturing these and do this in a way that avoids the bureaucracy of public sector procurement and performance management

Experiment and learn

It should be clear from this description of how INTs could develop that change will need to be largely bottom-up, adapted to the local context and that some of it will be based on experiment. This is very different from the standard model of change used in the NHS.

However, it is not desirable or justifiable for there to be multiple models of access to GP appointments or very different service offers to the public within a place or across an ICB. Recent research with the public by Imperial College Health Partners found that there was an expectation of a consistent approach to triage across London and a basic level of services that is the same everywhere. There is also an argument that basic systems do not need to be reinvented multiple times. Working out what needs to be standardised and where locally tailored services are needed is very important. In fact, even though the NHS has a very top down and centralised culture there is probably much more variation in what is offered and how it is organised than is optimal. INTs need to work together with ICBs and other stakeholders to work this through. Implementing standardised processes for relatively simple activities will save time and money but as with the other changes here sufficient time and resources for implementation need to be allowed. Tailored approaches are needed to deal with particularly complex issues or local contingencies but of knowledge between INTs can reduce the need for solutions to be developed from scratch.

Developing INTs and their ways of working through experiment and co-production with staff will require investment in training in improvement methodology and in ensuring that teams have sufficient time to do this work.

The development of learning models such as NAPCs “active learning” approach and feedback that collect data on performance should be a key feature of the new model and one that will allow it to evolve and adapt over time.

Delivering on other priorities

The development of INTs will help to deliver a neighbourhood NHS although there remain some questions about the extent to which there is a core of standard services and approach that is mandated. The adoption this approach to the creation of INTs can also help to deliver on other priorities. Simplifying internal processes and the development of a clearer understanding of the needs of the population and taking a more proactive approach will positively affect access times for GP and ED. Some waiting lists can also be better managed with input from the INT about whether patients are on the most appropriate treatment pathway and activated patients with decision support are potentially an important part of this for some conditions, especially MSK.

A focus on working with and supporting citizens and with communities will also allow INTs support other agencies and VSCE in dealing with inequalities, social determinants of poor health and in helping people to return to work. For example, our work has shown how using

targeted social prescribing has reduced sick leave and fit notes issued by 30-50% in group.

INTs and ICBs can work together to develop new approaches to resource allocation using segmentation data to replace the Carr-Hill method with local solutions that will better reflect need and workload.

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What this means for national bodies and ICBs

The traditional model of managing this type of change in the NHS is not working. INTs need to be enabled and supported, they need investment in training, organisational development and space and time to grow. They do not need templates, large amounts of upward reporting and many of the other aspects of programme management that squashed much of the life from the Vanguard programme. The risk with pilots, front-runners and other accelerated models is that they can suggest that people should wait to see what is going to happen. It is well understood that the rhetoric that people need to develop meaningful local solutions quickly transforms into instructions to pass a particular set of tests or adopt a nationally set approach. These schemes also often pick areas that are already successful or fail to provide enough time for relationships to develop. They do not seem to be effective at spreading good practice as peer-to-peer learning is not generally done very well.

INTs will need protection from the management of policy priorities by large numbers of vertical programmes each with their own model of change and budget and in many cases a willingness to run past existing lines of accountability. Indeed, this model may need a more fundamental review. This will mean that new approaches to leading transformative change will have to be learned and learning from the 2000s should be revisited to inform this.

National action is needed on a number of areas:

- To provide the digital front door and a powerful NHS app that can help INTs deal with demand and empower patients.
- A GP contract that addresses some of the serious issues in GP at present and provides a flexible approach to developing new models of care. The one-size-fits all approach is not appropriate now, if it ever was.
- Dealing with the obstacles to data sharing whether this is the data controller role or different interpretations of the rules across different parts of the NHS and local government. It should not be acceptable for electronic record providers not to have open APIs or to interface with the NHS App.
- Investment in other infrastructure – both physical and digital need to support the change
- Expanding the funding for community health workers

The approach to workforce development needs to be reviewed in the light of some of the learning from ARRS and the recent controversy about the role of PAs. The development of the PCN contract has put a focus on roles but teams need a mix of skills and where possible more people with a wide range of generalist skills. Fragmenting care into lots of different tasks increases handovers and the risk of miscommunication and it also means an increased burden and cognitive load for whoever is supervising. The holistic view of the patient may be lost or need to be rebuilt by creating care coordination roles, rather than this being a key part of everyone's work. All this may also make for less rewarding work. INTs need a new approach.

The widespread use of improvement methods needs to be a key part of how INTs work. This is an area where a national approach to developing skills, expertise and methods would add value.

There are fundamental questions about the Care Quality Commission (CQC) and its role currently being asked but it is clear that it will need a different approach that is more tolerant of experiment and learning.

Some questions remain to be debated:

- Should there be a single approach to segmentation? Spain has adopted a common model across all of its autonomous communities.(15) This would provide a much better basis for resource allocation and a revision of Carr Hill as well as improving population level analysis.
- What should be standardised in terms of a core offer to the population?
- How can ICBs support changes in resource allocation that address long standing inequity in how services are distributed?
- Commissioning has been badly degraded by organisational change and it is a good time to reconsider what its role is, how it works and how it can support these changes to develop a more value-based approach
- The accountability arrangements and the role of the place-based partnerships need to be worked through.

What are the measures of success and how can these create shared purpose across all parts of the health and care system.

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Conclusions

In the areas where we have seen glimpses of success, they are typified by:

- A **bold shared ambition**, leadership bravery and active championing.
- Acknowledgement that **commitment alone is not enough -** teams need to be **afforded the time** to put into the effort to realise the ambition
- A balanced **bottom-up and system wide approach, with a focus on the needs of population**
- An **approach centred on building effective and trusting relationships** and effective team processes – changing the culture and working practice
- A **focus on getting both the workforce and the population engaged in new ways**
- A culture and willingness **to try, succeed or fail, and learn**
- A sense of **ownership and having built the model yourself** rather than it being imposed including having meaningful control over resources including delegated budgets for key areas of activity
- A recognition that **no one size sits all** – options explored and developed in response to local requirements and changing landscape but where appropriate, a desire to **solve the big challenges together and do it once** – digital, estates, governance and data sharing etc.

Some of the big challenges and enablers need national attention: opportunity to relax some contract requirements to allow for greater local flexibility; supporting the evolution of the regulatory system to adapt to a more integrated model; exploration and support for some of the emerging target operating models.

Much of this development work will happen within the INTs themselves but there is a crucial role to support this and provide system level integration and other support at place or ICB level. How this is to be done requires further thinking and is the subject of work in progress by NAPC.

The vision is clear, and the evidence is strong, but getting there is complex. Systems can't do this this in isolation. They need to go on this journey together and learn together.

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