

# GET WELL SOON

REIMAGINING PLACE-BASED HEALTH

The Place-Based Health Commission Report

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Any mistakes or omissions in the report are the authors' own.

**NLGN** and **COLLABORATE**

# FOREWORD

**We are not short of perspectives on the future of health and social care in England, and nor are we struggling for consensus about the things that would help our system to reach sustainability.**

The Five Year Forward View is, for example, quite clear about the need for a ‘radical upgrade’ in prevention and public health, a blurring of care settings and silos, and a more diverse delivery model that has citizen voice and experience at its heart. The findings of the recent Mental Health Taskforce reinforce the need for a more ‘preventative and proactive’ approach that ‘breaks down barriers’. And the 2014 Barker Review is one of many calls for more fundamental integration of finance and commissioning across the health and social care divide.

What is also quite clear is that policy and practice remain disconnected. Perverse incentives still frequently undermine progressive intentions, prioritising organisational integrity over system accountability. Across the NHS, local government and beyond, there has been a failure to make good on the promise of deeper engagement with citizens.

I agreed to chair this Commission because its remit has been somewhat counter-cultural. I wanted us to ask: What would a conversation about the future of health and care look like if it didn’t start with existing health services? If ‘place’ was our unit of analysis (rather than institutions), could we bring new insight into the change process? And most importantly, what are practitioners telling us about the things that really enable outcome-focussed collaboration at a local level?

In an attempt to answer these questions, the Commission’s research team has worked with groups of local partners in the North East, the West Midlands, East Anglia and Greater London – as well as collecting written and survey evidence from a broader constituency across the health, local government and third sectors. I am indebted to these contributors, and to our Commissioners for adding their own insight and analysis to the process.

Our findings are presented here. The report tells us much about the relationships between institutions that need to be built, and about the ways in which services could be knitted together more effectively for people who need them the most. It suggests that, if we are ever to achieve our ‘radical upgrade’ in prevention, we need to share the future of the health and care system beyond the borders of our current service silos.

It also reminds us that *place matters* – and if we are really serious about reorienting our health and care model around the grain of people’s lives, assets and ambitions, then we need to take it seriously as a starting point for reform.

## **LORD VICTOR ADEBOWALE CBE**

**Chair, Place-Based Health Commission**

# LIST OF COMMISSIONERS

## **CHAIR: LORD VICTOR ADEBOWALE CBE**

Chair, Collaborate and Chief Executive, Turning Point

## **VICE CHAIR: RT HON STEPHEN DORRELL**

Chair, NHS Confederation; Member of the UK Parliament from 1979-2015 and Secretary of State for Health 1995-1997

## **MIKE ADAMSON**

Chief Executive, British Red Cross

## **ANDREW BURNELL**

Chief Executive, City Health Care Partnership

## **RUTH COOKE**

Chief Executive, Midland Heart

## **STEPHEN DALTON**

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## **CLLR RUTH DOMBEY**

Leader, London Borough of Sutton

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UK Director of Communications and Patient Relations, Abbvie

# EXECUTIVE SUMMARY

**There is widespread consensus that our health and social care services are not sustainable in their current form. Demand pressures are growing and funding has failed to keep pace. The gap between need and resources could rise to £25 billion by 2020.<sup>1</sup>**

More money may be necessary, but it is far from sufficient. Health spending must shift away from treatment and towards prevention. The focus must be on keeping people well for longer and, when they do become ill, supporting them to manage their conditions in the community, avoiding expensive institutional settings. This is not a new analysis: those involved in health and social care reform have recognised this for some time but to date transformation on the scale required has proved elusive.

If we are to take Sir Michael Marmot's call for a focus on the broader determinants of health seriously, people must be put at the heart of reform. This means reimagining a new health and wellbeing system which promotes personalisation, supports healthy decisions, enables physical activity and encourages responsibility.

## THE CASE FOR PLACE-BASED HEALTH

If we ask a person "what health services do you want?" the answer might well be clinical and focussed on a more efficient experience. But if we ask that same person "what would help you to enjoy life more?" the answer would be different: perhaps about their lived experience at home, in the community and at work, and their hopes for the future.

In this report, we set out how a system for health and wellbeing that begins with the latter question can be achieved. To do so requires the NHS to

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<sup>1</sup> This figure is based on NHS England's identified £22 billion of productivity improvements required by 2020 and the estimated social care funding gap which is estimated at between £2 billion and £2.7 billion over the same time period. See Nuffield Trust, Health Foundation and The King's Fund (2015), *The Spending Review: What Does it Mean for Health and Social Care?*

broaden its focus and build stronger bridges to people. This would involve bringing expertise from local government, community pharmacy, the voluntary, community and social enterprise sector, housing providers and other local services together to effectively confront the broader drivers of poor health.

We call this approach place-based health.<sup>2</sup>

By integrating health, local government, housing and other services across a geographic area (which could be a city region, town or neighbourhood), we believe we can reengineer the system to secure better outcomes and become sustainable for the future. Data gathered for this report suggest that most local authority and health professionals agree that a place-based system could reduce demand and deliver net cost savings to healthcare.<sup>3</sup> Around 65 per cent of our survey respondents cite prevention as a high priority today, and almost 100 per cent believe it should be a high priority in future.

Evidence from high quality international health systems and early findings from integrated personal commissioning and small-scale studies from areas such as Greater Manchester support the idea that early intervention and prevention improves outcomes and potentially saves money in the longer term. For example, Nesta estimated that over £4 billion could be saved with more direct involvement of patients, families and communities in the management of long-term conditions.<sup>4</sup>

Parts of the NHS and local government are already taking steps to turn high-level consensus into a reality on the ground. The Vanguard sites and devolution of health budgets to Greater Manchester and Cornwall are notable examples, and other cities and localities are developing their own autonomous plans. And yet something is still missing. It is relatively easy to point to individual promising examples of change, but these do not yet amount to the systemic shift in culture and practice that needs to be made. The Place-Based Health Commission was established by NLGN and

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<sup>2</sup> NLGN and Collaborate (2015), *Place-Based Health: A Position Paper*.

<sup>3</sup> See Annex 2

<sup>4</sup> Health Foundation and Nesta (2016), *At the Heart of Health: Realising the Value of People and Communities*

Collaborate to consider how this ‘systemic shift’ can occur in practice. The Commission investigated four areas where the process of change has already begun – Birmingham, Suffolk, Sunderland and Sutton – and carried out original research amongst practitioners.

One early conclusion was that waves of structural, top-down reform have been pushed out in a way that is disconnected from the experience of local practitioners. So we have deliberately taken a different approach: to look between the lines and concentrate on the enablers and relationships that could help a place-based health system to work on the ground.

## THREE CHALLENGES FOR TODAY’S SYSTEM

Our findings lead us to conclude that reform is being held back by three interrelated factors:

- **THE EVIDENCE PARADOX:** operational and financial pressures mean that NHS agencies are often reluctant to invest in prevention because they lack clear evidence that it will save them money. This is understandable, but it is in danger of becoming a circular argument. If we never attempt to deliver place-based health, we can never prove that it works. The emphasis must be on local government to make serious attempts to turn the rhetoric into reality, and to rigorously evaluate these attempts. But councils can only do this if the NHS is more open to experimentation and local variation.
- **POORLY ALIGNED INCENTIVES:** councils and health providers work to very different sets of organisational and financial incentives, which often drive them to work in isolation from each other. We need to focus much more on how to devise new ways of working together. This should translate the language and culture of different systems and incentivise a different set of behaviours. These are the ‘soft’ enablers that in reality are the hardest of all.
- **RIGID REGULATION:** too many parts of the public sector operate under heavy and inflexible forms of national regulation which stymie local change. The direction of travel from the centre is positive: for example a Care Quality Commission commitment to explore ‘Quality

of Care in a Place'; NHS England and Health Arm's Length Bodies' recently published planning guidance; and emerging flexibilities for local government. But much more remains to be done to enable local initiatives to create more impact and scale up quicker.

## THREE SHIFTS FOR PLACE-BASED HEALTH

The Commission brought together expertise from national, regional and local levels of the health and care system. We have drawn insight from credible local practice and different ways of working, and this is reflected in our focus. We believe three shifts are required to move the system sustainably towards place-based health:

### ■ **SHIFT ONE: FROM INSTITUTIONS TO PEOPLE AND PLACES**

Health and care institutions currently hold the power and determine the direction of service delivery, often at a distance from people as assets and the resources of places. If the system is to shift towards prevention and embed health as a social movement, people's capacity and local resources need to be leveraged much more effectively and become integral to place-based health.

### ■ **SHIFT TWO: FROM SERVICE SILOS TO SYSTEM OUTCOMES**

Separate services are currently set up to work to their own organisational priorities. Moving from the dominance of vertical silos of 'health' and 'care' to horizontal place-based systems will involve cultural and behavioural change on a completely new scale. Enablers of this change need to be recognised, developed and supported at every level, to then lead the creation of a new system from the inside out.

### ■ **SHIFT THREE: ENABLING CHANGE FROM NATIONAL TO LOCAL**

Changes in local practice and behaviour must be supported by the national policy framework. National bodies must focus on creating a long-term environment for prevention, approaching places as whole systems rather than reinforcing silos, and removing blockages for local practitioners.

## FIVE ENABLERS FOR PLACE-BASED HEALTH

The Commission sets out five enablers for place-based health to be realised in practice. These have implications for local practitioners and national policymakers:

- **EMBED LONG-TERM PLANNING** – we propose a Fifteen Year Forward View for place-based health which would be designed to overcome the short term operational and political pressures that prevent a focus on transformation. This would galvanise everyone within the system to work towards the same goals. It would act as a blueprint to create an agreed vision of place-based health, building on the Five Year Forward View, the Sustainability and Transformation Planning process and the emerging devolution framework. Working in a similar way to the National Infrastructure Commission, this plan would focus solely on the changes critically needed to create essential long-term transformation.
- **AN EXPLICIT FOCUS ON BREAKING THROUGH THE EVIDENCE PARADOX** – building credibility in the investment case for prevention is vital. Without it we will never be able to re-balance spending in a sustainable way. It is the other side of the coin to the recent call for a cross-party consensus on sustainable funding.<sup>5</sup> We champion local efforts and support a commitment from Public Health England and the Chartered Institute for Public Finance and Accountancy (CIPFA) to create a set of professional standards for creating place-based business cases for investment in prevention and early intervention. We believe this will be essential to building confidence in the process.
- **A RENEWED PUSH TOWARDS INTEGRATED LOCAL COMMISSIONING** – commissioning integrated services to meet the holistic needs of people has failed to gain traction. This is in part because we have dramatically underplayed the role of two functions: the role of ‘system translators’ who can cross boundaries and build trusted relationships; and the presence of ‘commitment devices’ which use financial, technological and market levers to hold systems to

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<sup>5</sup> See BBC (6 January 2016), ‘Cross party review needed for health and care’, available at <http://www.bbc.co.uk/news/health-35233346> [accessed February 2016].

account on the basis of outcomes. Recognising and investing in these enabling people and functions are essential ingredients of place-based health, and we offer some perspectives on how to do this.

- **A ROUTE MAP TOWARDS PLACE-BASED HEALTH** – working towards 2030 we outline a route map to achieve population-level planning and commissioning, different models of devolved governance, and a system driven by a relentless focus on citizen outcomes. This will be delivered by a step-change in the nature and quality of out-of-hospital care. The foundations of this need to be laid immediately: with much better and more consistently used insight into the grain of communities and the aspirations and assets of people. Without this, better outcomes through accountable care will be a vision built on sand.
- **A SYSTEMATIC APPROACH TO BUILDING READINESS FOR CHANGE** – our evidence suggests an incredible thirst for innovation and an appetite to pursue new ways of achieving better results for people and places. But the flipside is also evident: a weariness borne of ambitious initiatives that failed to stick because they lacked a credible account of how change happens on the ground. If we are to make place-based health work, then we need to invest in a transformation process that will take us to joint workforce planning, place-based outcome agreements and collaborative accountability frameworks that hold a range of organisations to account for outcomes in a place.

The Place-Based Health Commission's approach is designed to enable local practitioners to press ahead with reforms. At the same time we seek to build in healthy disruption to a system that, more than ever, requires exactly that. If people are to have more control and responsibility for their own health and wellbeing outcomes, the system needs to shift wholesale towards enabling rather than disempowering this.

Our report seeks to progress debate into practical territory, beyond institutions and services towards people and places. Our shared commitment is to play a role in beginning to make this happen in practice.

# THE CASE FOR CHANGE

Our health and care system is not sustainable in its current form. The NHS faces a funding gap of £22 billion and social care faces one of up to £2.7 billion by 2020.<sup>6</sup> The position is only likely to worsen as the population continues to age over subsequent decades. This is despite the Government finding £7.6 billion in the Spending Review<sup>7</sup> to help keep the NHS viable until the end of the decade: much of this will be soaked up by hospital deficits at the expense of spending on prevention and wellness.

While some NHS budgets are relatively protected, public health and social care budgets are falling.<sup>8</sup> This risks creating a vicious cycle whereby cuts to preventative and community-based services create unmet demand which drives ever more people into A&E, pushing up demand for hospital services and putting even more pressure on governments to fund crisis treatment at the expense of prevention.

More money is undoubtedly part of the answer, but the sums required to put an unreformed NHS on a sustainable footing would involve either the largest increase in personal taxation for 40 years or gigantic cuts to other public services. According to some economists, the amount necessary is £43 billion a year, very nearly as much as the spending power of every English council put together.<sup>9</sup>

There has to be another way.

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<sup>6</sup> Nuffield Trust, Health Foundation and The King's Fund (2015), *The Spending Review: What Does it Mean for Health and Social Care?*

<sup>7</sup> *Ibid.*

<sup>8</sup> *Ibid.*

<sup>9</sup> The Guardian (16 February 2016), 'Income tax must rise 3p to stop NHS 'staggering from year to year'', <http://www.theguardian.com/society/2016/feb/16/income-tax-must-rise-3p-to-stop-nhs-staggering-from-year-to-year> [accessed March 2016].



The Place-Based Health Commission was convened by NLGN and Collaborate.<sup>10</sup> It proceeds from the widespread recognition – notably championed by Sir Michael Marmot – that 20 per cent of an individual's health outcomes result from clinical treatment, with the remaining 80 per cent determined by wider factors such as lifestyle choices, the physical environment and social networks.<sup>11</sup> Only by addressing these factors<sup>12</sup> can we create a healthier population and address challenges such as health inequality, where the gap between rich and poor is currently the highest it has been since records began.<sup>13</sup>

We believe that integrating services across a geographic area will result in a better-coordinated set of services which deliver higher quality care and are likely, over time, to reduce demand for acute care. We are aware that this is not a new idea. Indeed, it reflects a burgeoning consensus about the principles that should inform future healthcare. The burning question is how a systemic shift towards place-based health can be achieved, and that is what we set out in this report.

We seek to move beyond the integration of health and social care to take a much broader view of the role of housing, community pharmacies, businesses, the voluntary and community sector, social enterprises and people themselves. The proposals in this report are for both local practitioners and national policymakers. They focus on culture, behaviour and practicalities more than they do on structural reform. They do so in the context of the three 'gaps' in the health and care system highlighted in the Five Year Forward View<sup>14</sup> (health and wellbeing; care and quality; and finance and efficiency) because place-based health needs to achieve better health and wellbeing outcomes, higher quality of care and a sustainable system. We develop the approach beyond 'one size fits all', driven by NHS

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<sup>10</sup> NLGN and Collaborate (2015), *Place-Based Health: A Position Paper*.

<sup>11</sup> Cited in British Academy (2014), *'If You Could Do One Thing': Nine Local Actions to Reduce Health Inequalities*; Marmot, M. (2008), *Fair Society Healthy Lives*.

<sup>12</sup> See Public Health England (2014), *From Evidence into Action: Opportunities to Protect and Improve the Nation's Health*.

<sup>13</sup> Dorling, D, Shaw, M, and Davey Smith, G., 'Inequalities in Mortality Rates under New Labour' in Dowler, E. and Spencer, N. J. (2007), *Challenging Health Inequalities: From Acheson to Choosing Health* (Bristol: Policy Press).

<sup>14</sup> NHS England (2014), *Five Year Forward View*.

England including through the latest NHS Shared Planning Guidance,<sup>15</sup> to one that enables new local models of care to develop and place-based systems transformation to occur.

## THE CHALLENGE OF CHANGE

There is a long-standing consensus in the health sector that the only way to put the NHS on a sustainable basis is to shift funding and effort upstream, moving it away from expensive forms of treatment and towards new forms of early intervention and prevention and self-management of care. This dates back to at least the early 2000s, when the Wanless Review<sup>16</sup> justified increased NHS spending by arguing that long-term cost pressures would be contained by greater citizen engagement in managing their own health. That vision has not yet been realised. While there has been some progress in areas like reducing smoking, increases in lifestyle-related health issues such as diabetes and obesity have emerged to fill the gap. The problems that the Wanless Review anticipated continue to undermine the medium-term sustainability of both the NHS and the wider system of organisations that support health and wellbeing.

We face a substantial gap between intention and action. The Commission carried out a survey of health, local authority and voluntary sector experts to take the temperature of the sector.<sup>17</sup> Virtually every one of our survey respondents agreed that prevention should be a major priority for the future sustainability of the NHS. Over 80 per cent of local authorities said that it was actually a high priority in their locality, compared to just over half of health sector respondents (See Figures 1 and 2).

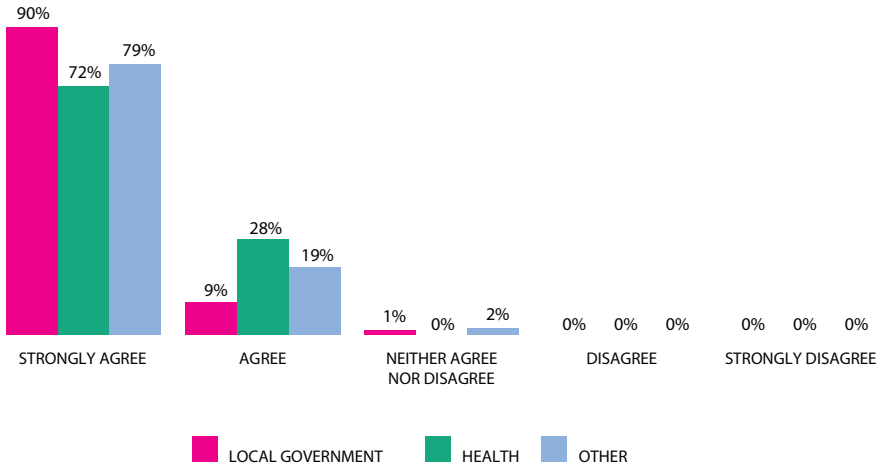
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<sup>15</sup> NHS England (2015), *Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21*.

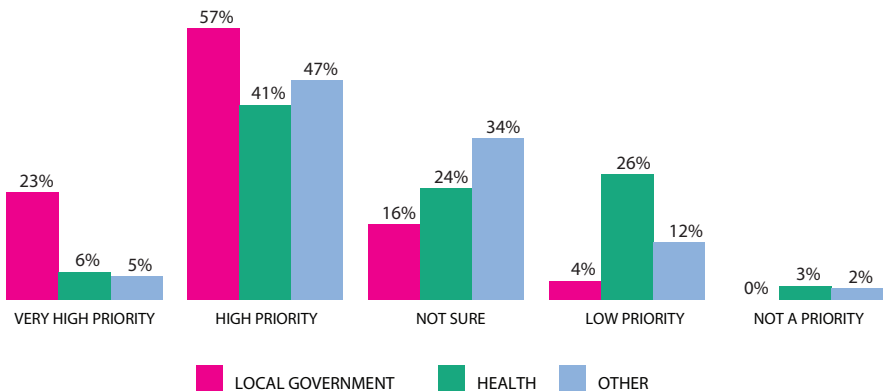
<sup>16</sup> Wanless, D. (2002), *Securing Our Future Health*.

<sup>17</sup> The survey was sent out to over 2,000 health professionals, local government officers, and a cross-section of the private and third sectors and was in field for four weeks in July 2015. There were 231 respondents, of which 45.5 per cent were from local authorities, 29.4 per cent were from the third and other sectors, and 25.1 per cent were from the health sector. For more details see Annex 2.

**FIGURE 1** TO WHAT EXTENT DO YOU AGREE THAT EARLY INTERVENTION AND PREVENTION SHOULD BE A MAJOR PRIORITY FOR THE FUTURE SUSTAINABILITY OF THE NHS?



**FIGURE 2** HOW MUCH OF A PRIORITY IS EARLY INTERVENTION AND PREVENTION IN YOUR LOCALITY?



The problem with achieving prevention and early intervention is not convincing people that it is the right thing to do, but making it happen at a time of huge policy change and very tight budgets. As so often, the need to solve today's crisis is stopping us from addressing tomorrow's. As two of our survey respondents put it:

*"There's always a lot of positive 'noise' regarding prevention but due to budgets essential services take priority"*

Public health manager

*"[There is a] lack of drive in the council and the NHS to make a change – [they] act like it's someone else's problem for later"*

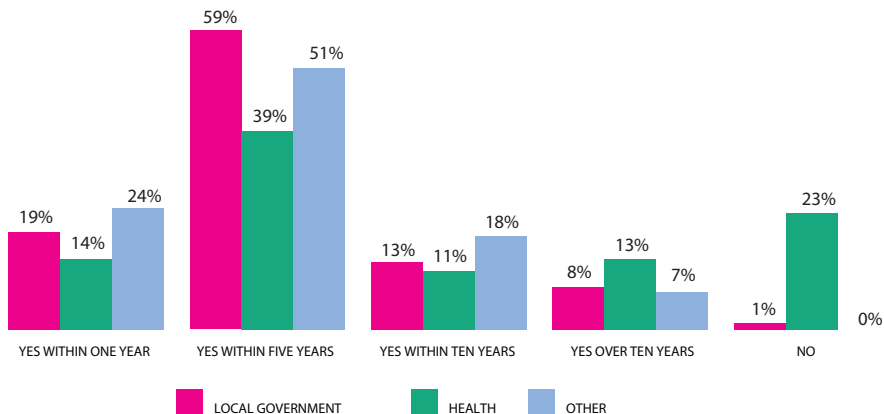
Private care provider

## THE EVIDENCE PARADOX

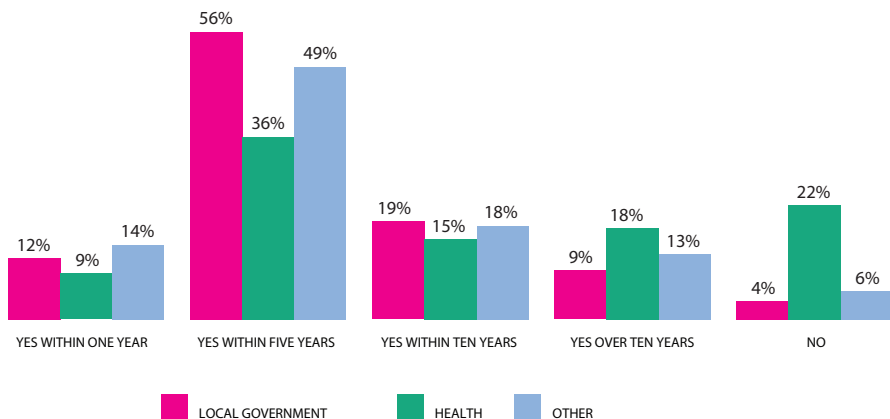
A lack of good data about the benefits of prevention has become a reason not to implement the reforms which would generate that evidence. This is what we call the evidence paradox. One challenge is that the short-term nature of funding cycles conflicts with the longer period over which any evidence of the impact of prevention is borne out. Another challenge is that the health world is driven by quantitative measures through hard clinical data, and local government largely adds qualitative value delivering less measurable quality of life care and wellbeing outcomes.

We uncovered differing expectations between local government and health professionals as to whether early intervention and prevention would reduce demand on the NHS, defer or reduce costs, and over what time period (see Figures 3 and 4). Around one-in-five health professionals were sceptical that it would achieve either.

**FIGURE 3** WOULD YOU EXPECT EARLY INTERVENTION AND PREVENTION INITIATIVES TO SIGNIFICANTLY REDUCE DEMAND ON THE NHS?



**FIGURE 4** WOULD YOU EXPECT EARLY INTERVENTION AND PREVENTION INITIATIVES TO SIGNIFICANTLY DELIVER NET COST SAVINGS?



Although the costs of doing nothing mean inevitable service overstretch, this creep of crisis itself has not been enough to create the transformation required. To overcome this systemic paralysis, partners need to work together to manage expectations and ensure a new outcomes model stacks up according to their differing methodologies. While health partners cannot expect evidence that mirrors the robustness of a controlled clinical trial, local government cannot expect health partners to invest significant sums of money upfront based on anecdotal evidence alone. Both must play a part.

## FUNDING PRESSURES

Health and social care are two sides of the same coin, yet only health has had its funding relatively protected. Even so, the NHS has a forecasted £22 billion funding gap by 2020, despite an additional £7.6 billion invested upfront by the Government in the last Spending Review.<sup>18</sup> Public health suffered in-year budget cuts of £200 million in 2015/16, and the Spending Review confirmed that there would be further four per cent annual cuts over the rest of the parliament.<sup>19</sup> The introduction of a new two per cent social care precept on council tax will not cover the increase in costs associated with the National Living Wage let alone deal with the rising demand from the over 65s.<sup>20</sup> The Commission supports calls for a new national consensus over how to pay for the costs of an ageing population in which younger people with disabilities and long-term health conditions are living longer too.<sup>21</sup> But without reform to the health system there is a danger that no realistic amount of public funding will be able to meet demand.

## DEMOGRAPHIC PRESSURES

Our population is ageing: life expectancy when the NHS was created in 1948 was 66 for men and 70 for women; in 2014 it was 79 and 83 respectively.<sup>22</sup>

<sup>18</sup> Nuffield Trust, Health Foundation and The King's Fund (2015), *The Spending Review: What Does it Mean for Health and Social Care?*

<sup>19</sup> See <https://www.gov.uk/government/consultations/local-authority-public-health-allocations-2015-to-2016>, [accessed January 2016].

<sup>20</sup> LGA analysis estimated that the cost of implementing the National Living Wage would cost councils £1 billion. See: [http://www.local.gov.uk/media-releases/-/journal\\_content/56/10180/7386419/NEWS](http://www.local.gov.uk/media-releases/-/journal_content/56/10180/7386419/NEWS), [accessed January 2016].

<sup>21</sup> See BBC (6 January 2016), 'Cross party review needed for health and care', <http://www.bbc.co.uk/news/health-35233346> [accessed February 2016].

<sup>22</sup> Source: [www.ons.gov.uk/ons/rel/social-trends-rd/social...41/health-data.xls](http://www.ons.gov.uk/ons/rel/social-trends-rd/social...41/health-data.xls) [accessed October 2015]; Office for National Statistics (2015), *National Life Tables, United Kingdom, 2012–2014*.

The proportions of our population over the ages of 65 and 85 are rising.<sup>23</sup> Two further demographic shifts have also emerged to create demand pressures. Firstly, there are more people living with one long-term condition, and increasing numbers with multiple long-term conditions.<sup>24</sup> This places a greater urgency on the need to effectively support people to self-manage their conditions and remain independent.

Secondly, there is an increasing prevalence of 'lifestyle-related' illnesses, linked to unhealthy behaviours such as obesity or excessive alcohol consumption which lead to problems like diabetes or liver failure.<sup>25</sup> This places a greater priority for the system to more effectively focus on individuals' choices and support them to live healthier lives. As more of us live longer with a mixture of physical health, mental health and social care needs that defy traditional organisational boundaries and budgets, a different model of delivery is needed which offers people well-coordinated services that are joined-up around their individual needs and preferences.

## THE ROLE OF PLACE

Health inequalities persist and there is a significant geographical element to them: where you live is still a key determinant of how long you will live. For example, a boy born in South Cambridgeshire in 2013 is expected to live 8.7 years longer than a boy born in Blackpool at the same time.<sup>26</sup> A 'one-size-fits-all' model of health provision is geared towards creating standardised services, but over the years this has failed to prevent a postcode lottery of life expectancy.

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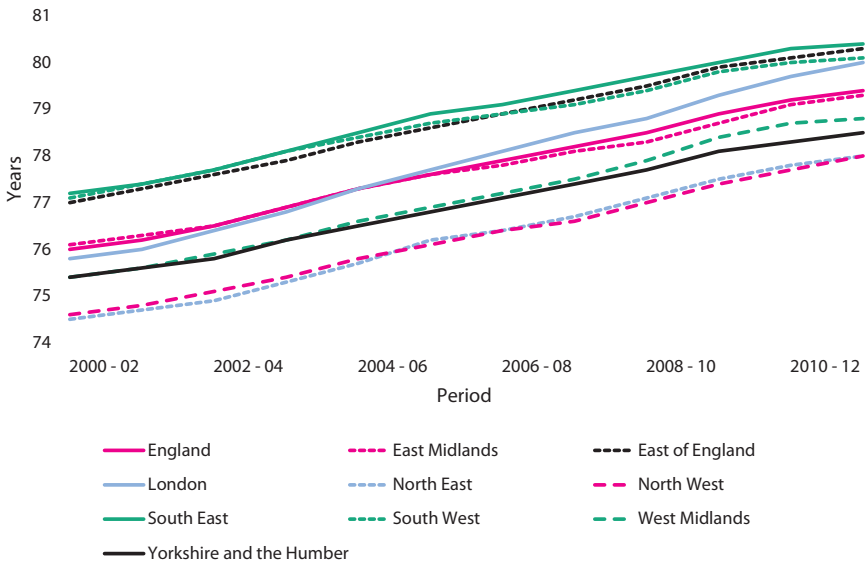
<sup>23</sup> For more detail see Office for National Statistics (2012), *Population Ageing in the United Kingdom, its Constituent Countries and the European Union*, [http://www.ons.gov.uk/ons/dcp171776\\_258607.pdf](http://www.ons.gov.uk/ons/dcp171776_258607.pdf) [accessed October 2015].

<sup>24</sup> In 2014 there were 15.4 million people living with a long-term condition, and 1.9 million with three or more, which is projected to rise to 2.9 million by 2018. See <https://england.nhs.uk/resources/resources-for-ccg/out-frwrk/dom-2/> [accessed February 2016].

<sup>25</sup> Obesity is estimated to cost the NHS £5 billion a year. Source: Department of Health (2015), *Policy Paper: Obesity and Healthy Eating*.

<sup>26</sup> Office for National Statistics (2014), *Life Expectancy at Birth and at Age 65 by Local Areas in England and Wales, 2011–13*, see <http://www.ons.gov.uk/ons/rel/subnational-health4/life-expectancy-at-birth-and-at-age-65-by-local-areas-in-england-and-wales/2011-13/stb-life-expectancy-at-birth-2011-13.html> [accessed October 2015].

**FIGURE 5** LIFE EXPECTANCY AT BIRTH (MALE)<sup>27</sup>



**FIGURE 6** LIFE EXPECTANCY AT BIRTH (FEMALE)



<sup>27</sup> Source: Public Health Outcomes Framework data tool <http://www.phoutcomes.info/public-health-outcomes-framework> [accessed February 2016].



International examples such as Denmark, Sweden and Norway demonstrate that decentralised healthcare systems can go hand-in-hand with high quality services and good outcomes (see Shift Three of this report). There is emerging evidence that our top-down approach is not delivering quality: a recent OECD report into the UK Health and Care System found that, “on balance the UK does not consistently demonstrate strong performance on international benchmarks for healthcare quality, despite having prioritised quality assurance, monitoring and improvement work for many years”.<sup>28</sup> The wider role of places and local decision-making to organise services more effectively is beginning to come into sharper focus.

## PROGRESS TO DATE

There has been progress in the direction of place-based health.<sup>29</sup> Public health functions were returned to local government in 2013. The NHS has started to adapt. The Five Year Forward View has rallied the system to focus on the urgency of the challenge. It has placed a distinctive emphasis on prevention, locally-developed new models of care, and health as a social movement, to realise more equitable health outcomes, a better service and cost savings.<sup>30</sup> This ambitious agenda is being driven by NHS England alongside new efforts to control quality variation and cost within existing provision.<sup>31</sup>

The Government has negotiated the devolution of health budgets in Greater Manchester and Cornwall from April 2016. Further locally-focussed initiatives such as the London Deal of five health pilots in the capital<sup>32</sup> and NHS England designating 10 new healthy town housing developments to address major healthcare problems including obesity and dementia<sup>33</sup> have followed. All areas in England have Better Care Fund pooled budgets in place, and all

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<sup>28</sup> OECD (2016), *OECD Reviews of Health Care Quality, United Kingdom: Raising Standards*.

<sup>29</sup> See The King's Fund (2015), *Place-Based Systems of Care*.

<sup>30</sup> NHS England (2014), *Five Year Forward View*.

<sup>31</sup> Carter, R. (2015), *Operational Productivity and Performance in English NHS Acute Hospitals*; Berwick, D. (2013), *A Promise to Learn, A Commitment to Act: Improving the Safety of Patients in England*.

<sup>32</sup> See <https://www.gov.uk/government/news/london-deal-paves-way-to-transform-health-care-across-the-capital> [accessed March 2016].

<sup>33</sup> See <https://www.england.nhs.uk/ourwork/innovation/healthy-new-towns/> [accessed March 2016].

places must plan for health and social care integration by 2017 which should be fully operational by 2020.<sup>34</sup> New NHS planning guidance<sup>35</sup> requires Sustainability and Transformation Plans (STPs) from local areas, with locally-agreed geographical 'footprints'. This is an attempt at place-based planning: it is a starting point and, where locally the process is being broadened out, there is an opportunity to get beyond the traditional planning silos and the purchaser-provider split. But much will depend on the ability of local stakeholders to build relationships across NHS, local government, housing and voluntary sector boundaries.

There is a risk that NHS-led reform imposes a siloed institutional dominance to integrating health and care services, side-lining health and wellbeing boards which work to democratic decision-making boundaries and not aligned to 'places' as conceived by the people who live in them. These may not correspond to either traditional administrative boundaries or patient flows in complex health economies. In addition, a focus on efficiency within existing institutional models alone could detract from the more disruptive system transformation to shift the dominant culture and practice that is required.

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<sup>34</sup> HM Treasury (2015), *Spending Review and Autumn Statement 2015: Documents*.

<sup>35</sup> NHS England (2015), *Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21*.

# A NEW VISION FOR PLACE-BASED HEALTH

The starting point for the Place-Based Health Commission is to challenge the assumption that the future of the health and care system rests with those who currently lead it. If a new system is to reduce demand pressures and enable people to live healthier lives, then people themselves must be at the heart of reform. Wider assets of places including housing, businesses and the voluntary sector must also be part of this change. Instead of a system dominated by NHS structures and technocracy, we need one which puts local people themselves in the lead.

Our vision for place-based health centres on three core principles:

- **People** must be empowered to take greater control over their own lives, to influence personalised services and to take greater responsibility for their health outcomes
- All resources and assets in **places** must be used to support wider determinants of health and wellbeing outcomes
- A system shift towards **prevention and early intervention** will require services to organise and professionals to behave in very different ways.

A new vision for place-based health would realise a reversal of the current balance of funding and energy in the system away from crisis management and towards prevention (See Figure 7).

This would entail a very different approach to how the system works with people. If you ask a person “what health services do you want?” the answer will inevitably be clinical and focussed on a more efficient experience. If you ask a person “what would help you to enjoy life more?” the answer would be focussed more broadly about their lived experience at home,

in the community and at work, and their hopes for the future. This is the conversation that a system for health and wellbeing needs to begin with; a system that is reshaped to support the outcomes people themselves want to work towards.

**FIGURE 7** BALANCE OF RESOURCES<sup>36</sup>



To achieve this, services would be incentivised, commissioned and organised in very different ways to work with people, supporting them to live positive, fulfilling lives and activating existing channels of community or social networks. This will mean staff being trained differently, organisations linking into primary care, and health staff accessing information on resources in places to inform a different conversation.

Figure 8 sets out some example illustrations of the experience of the current system from the perspective of the individual, characterised by costly interventions and unresolved problems, compared to how the same experiences might be addressed under place-based health.

<sup>36</sup> Adapted from Suffolk Health and Wellbeing Board.

**FIGURE 8** WHAT PLACE-BASED HEALTH MEANS IN PRACTICE<sup>37</sup>**CURRENT SYSTEM****PLACE-BASED HEALTH****AT HOME****CURRENT SYSTEM**

My flat is poorly ventilated and it gets terrible damp. I keep asking my landlord to sort the problem out but he won't, there's no way to make him spend the money to get it fixed. I have scary asthma attacks and I keep going to my GP to get medication.

**PLACE-BASED HEALTH**

When I went to my GP about my asthma she asked about my housing situation. I told her about my damp problems and she told me how the local authority are really tough on landlords who fail their duty of care for tenants. It was great – they forced my landlord to fix the windows. These days I hardly ever have asthma attacks.

**IN THE COMMUNITY****CURRENT SYSTEM**

I know I shouldn't eat so much rubbish food but it's just easier. There are so many chicken shops on my way home from work, it's too tempting! I would exercise more but it's too expensive, and anyway I easily get sore knees. Now I'm worried because my doctor told me I was morbidly obese and have been diagnosed with Type 2 diabetes. I'm a bit scared about what that means but it's hard to break habits. I've been told I need to go back for regular check-ups so that's comforting.

<sup>37</sup> These are examples based on realistic scenarios but fictionally created to demonstrate the current and imagined future system in practice.

**PLACE-BASED HEALTH**

I went to my local pharmacist to get some painkillers for my knees and he said he could prescribe me some swimming sessions at the local leisure centre. I was a bit worried at first but he encouraged me. It's great fun and I've started doing it regularly. I met others who are also trying to lose weight and now we take it in turns to cook healthy meals for each other after a swimming session. We message each other in a chat group to keep us motivated if we are ever tempted by any fried chicken (there seem to be fewer of those shops around these days anyway...).

**AT WORK****CURRENT SYSTEM**

Of course I have a stressful job – who doesn't? I don't have time to do any exercise as I work really long hours, which also often means I get back quite late and just grab something. This healthy advice isn't practical when you have to work to pay the bills!

**PLACE-BASED HEALTH**

Our office has this new lunchtime running club. I wasn't sure I could make time for it at first but we got an email from management encouraging us to take part with a prize for the person who went to the most sessions. I met a guy there I have never spoken to before and now we've set up a regular rounders match between the accounts and management teams.

**OUT OF WORK****CURRENT SYSTEM**

I lost my job a while ago as I had a breakdown. The doctor diagnosed me with bipolar disorder and gave me some medication that had horrible side effects. I know I need to get a job but I have lost my confidence and the advice at the Job Centre is pretty basic - it's all very well teaching me interview techniques but what if it coincides with a dark spell? The more I think about it the more I dread that working will send me back down a spiral.

**PLACE-BASED HEALTH**

My support worker was great – she really understood me. She said I needed to get proper support for my bipolar first, and I've learnt some really good coping strategies for dealing with "triggers" – stress is a big one apparently. That really helped build up my confidence. It took a while but I have just started working again which is something I couldn't see happening just a short time ago. I find now that working gives me something to get up for in the morning, and my new job is at a company which has some sort of a national accreditation for promoting staff mental wellbeing and awareness, which made me feel like they'd understand my situation.

**LIVING WITH A LONG-TERM CONDITION****CURRENT SYSTEM**

I've barely been coping with my rheumatoid arthritis for years. When the pain flares up it's unbearable and I've been admitted to hospital several times. But it's feeling tired all the time that really gets you down and I struggle with even the most basic things. I get down quite a lot about it – I keep going to the doctors and I have lost track of the number of different people I've seen – nurses, rheumatologists, physios, you name it! It gets really annoying having to start explaining my situation from scratch each time and I'm sure I forget things. I have been on I don't know how many different types of medication.

**PLACE-BASED HEALTH**

My new support worker asked me the strangest thing at first – what I hoped for my future – I had been ready to try to remember all my patient history dealing with RA! We talked about what could change in my life and she knew what I had been through already from my records. She put together a personal support plan with a budget for some flexible carer support – someone to be on hand when a flare-up happens and I need instant treatment which before I could only get at hospital. I went on a course for people with RA and I learnt lots about how medications work – all the sorts of things you forget to ask in a quick consultation. Then I joined an RA peer support group to share what I had learnt – so I've had the opportunity to talk other people through the information and share tips for coping. Now I feel much more in control of my RA – it isn't dictating my life anymore.

## GROWING OLDER

### CURRENT SYSTEM

I get really lonely at home on my own – the days are so long when you have no-one to talk to! I sometimes even call up the GP to make an appointment just for someone to talk to. Last year I had a fall and had to go into hospital. I ended up being in there for a month as I developed an infection. I know a lot of people don't like hospitals, but I was actually glad of the company for a while!

### PLACE-BASED HEALTH

When I went to the GP about my toe she asked me how my day was and I said – much like any other really – I have the TV for company! Then she told me about a local group who match up neighbours with each other, some charity or other. Anyway the very next day, a nice young girl came round for a chat. She helped me get in touch with a local lunch club that was close by but I didn't know about. I've met so many people and I've even joined a local walking club – it's just a stroll around the park but it's so good to be active at my age! I set up a knitting club with some of my new friends and we are making blankets especially for babies born prematurely in the local hospital, which is putting my skills to good use!

### CURRENT SYSTEM

I had a stroke which left me with weakness on my left side and dented my confidence in whether I would be able to manage on my own at home. The hospital really needed the bed so I felt under great pressure to move into a care home.

### PLACE-BASED HEALTH

After my stroke the hospital social worker arranged for me to spend a few weeks at a local reablement service which helped me to do things for myself again. I began to feel much more confident and now I'm back at home, managing well and close to friends and family.



## THE PLACE-BASED HEALTH COMMISSION'S APPROACH

The Commission looked at the present system through the lens of places rather than from institutions that work from the top-down. There have been three phases of research:

- A survey of health, local authority and voluntary sector experts to seek views on core features of place-based health.<sup>38</sup>
- Four place-based evidence sessions, interviewing practitioners working on aspects of place-based health in Birmingham, Suffolk, Sunderland and Sutton.<sup>39</sup>
- The Place-Based Health Commission, chaired by Lord Victor Adebowale and involving fourteen Commissioners across sectors and geographical locations, met twice to give strategic direction and recommendations.

From this work, this report sets out three shifts that need to occur in the move towards realising a vision of place-based health:

### SHIFT ONE: FROM INSTITUTIONS TO PEOPLE AND PLACES

Health and care institutions currently hold the power and determine the direction of service delivery, often at a distance from people as assets and the resources of places. If the system is to shift towards prevention and embed health as a social movement, people's capacity and local resources need to be leveraged much more effectively and become integral to place-based health.

### SHIFT TWO: FROM SERVICE SILOS TO SYSTEM OUTCOMES

Separate services are currently set up to work to their own organisational priorities. Moving from the dominance of vertical silos of 'health' and 'care' to horizontal place-based systems will involve cultural and behavioural change on a completely new scale. Enablers of this change need to be recognised, developed and supported at every level, to then lead the creation of a new system from the inside out.

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<sup>38</sup> See Annex 2.

<sup>39</sup> See Annex 1.

### **SHIFT THREE: ENABLING CHANGE FROM NATIONAL TO LOCAL**

Changes in local practice and behaviour must be supported by the national policy framework. National bodies need to focus on creating a long-term environment for prevention, approaching places as whole systems rather than reinforcing silos, and removing blockages for local practitioners.

We take the approach of 'shifts' because structural changes have already been forced through from within the organisations that dominate the landscape. These proposals envisage practical and cultural change to catalyse and embed new ways of working.

# SHIFT ONE: FROM INSTITUTIONS TO PEOPLE AND PLACES

**Health and care institutions currently hold the power and determine the direction of service delivery, often at a distance from people as assets and the resources of places. If the system is to shift towards prevention and embed health as a social movement, people's capacity and local resources need to be leveraged much more effectively and become integral to place-based health.<sup>40</sup>**

This section sets out a sequence of phases designed to achieve a substantive shift from institutions to people and places. People need to be empowered to articulate and contribute to what they want from services. Better insight into places and local population level characteristics and drivers should be developed, including by better sharing of data. This insight then needs to develop clearer place-based outcomes and be used to plan and invest in services which ultimately overcome the evidence paradox.

## EMPOWERING PEOPLE

In 2002, Derek Wanless provided a compelling analysis of the case for engaging the public more actively in keeping themselves healthy.<sup>41</sup> By his reckoning, high levels of engagement would make the NHS £30 billion cheaper to run by the early 2020s. At a time when government spending is failing to keep pace with demand, the need to build individual agency, community capacity and social capital is well understood by professionals, but remains elusive in practice.

Our survey found that only 16 per cent of professionals believe that the general public are in any way engaged in their health (Figure 9).<sup>42</sup> Responses

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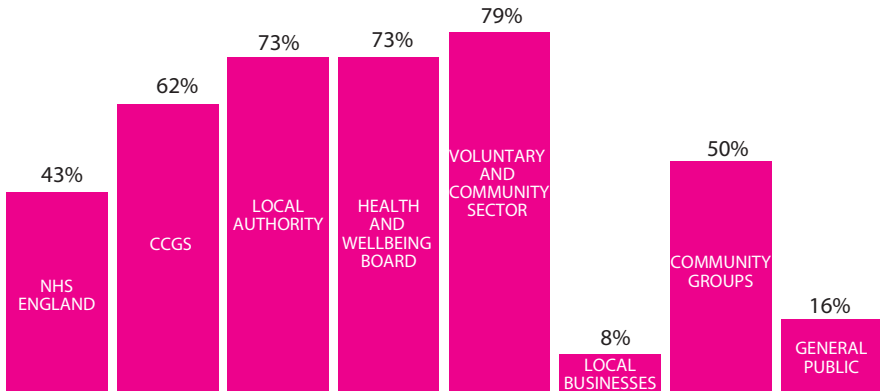
<sup>40</sup> Health Foundation (2015), *Head, Hands and Heart: Asset-Based Approaches in Healthcare*.

<sup>41</sup> Wanless, D. (2002), *Securing Our Future Health*.

<sup>42</sup> For more details on this finding, see NLGN and Collaborate (2015), *Place-Based Health: A Position Paper*.

revealed that services do not always encourage people to engage, for example one respondent said “engagement efforts are tokenistic, operational and poorly facilitated, in turn disengaging people”.

**FIGURE 9** PERCEPTION OF ORGANISATIONS BEING 'VERY ENGAGED' OR 'FAIRLY ENGAGED' IN EARLY INTERVENTION OR PREVENTION



Recent analysis strongly supports the case that empowering people can impact on demand reduction in reactive services. Nesta has predicted that taking a ‘people-powered’ approach to individuals with long-term conditions could deliver the NHS cost savings equivalent to £4.4 billion a year in England, potentially realised through interventions that reduce expenditure on A&E attendances, planned and unplanned admissions and outpatient admissions.<sup>43</sup> A more recent NHS England-funded report<sup>44</sup> found evidence that person- and community-centred approaches for health and wellbeing have significant potential to improve outcomes for individuals, support the development of strong and resilient communities and, over time, help reduce demand on formal health and social care services.<sup>44</sup>

<sup>43</sup> Nesta (2015), *The Business Case for People-Powered Health*.

<sup>44</sup> Health Foundation and Nesta (2016), *At the Heart of Health: Realising the Value of People and Communities*.

There are two levels at which people can be more empowered: both as individuals and through their insight to inform wider population-level system redesign. On an individual level, while people themselves may not be able to articulate what they would like the health system to look like as a whole, they can articulate what they would like from it when they personally need support. New asset-based methods such as the 'Three Conversation Approach' by Partners for Change seek to move away from a traditional 'assessments for services' culture and are demonstrating demand reduction where councils are using them.<sup>45</sup> Personalised 'single care plans' enable people to begin a conversation about their health starting with what goals and outcomes they seek to achieve. These should become more widespread and all professionals involved in health and care should recognise their value and be obliged to work to them.<sup>46</sup>

Yet multiple professional approaches to person-centred planning do not result in person-centred outcomes per se. So on a second, deeper level, personalised approaches need to inform a more fundamental system redesign. People's empowerment can often operate on the edge of the system – through consultation exercises run by a council communication team, outsourced to the VCS or owned by local Healthwatch – rather than at the core of every clinical and professional interaction with individuals. Empowerment happens, but it has not fundamentally disrupted the dominant culture and practice of the healthcare system.<sup>47</sup>

Figure 10 details the five steps on an arc of citizen engagement: inform, consult, involve, collaborate and empower.<sup>48</sup> We found that although many organisations within places have aspirations to move further along the arc, practice has not generally moved beyond consulting with the public. While all steps are valid approaches to engagement, the latter three are the most rewarding for the people involved and are the most focussed on building the individual and community resilience required for a shift from institutions towards assets.

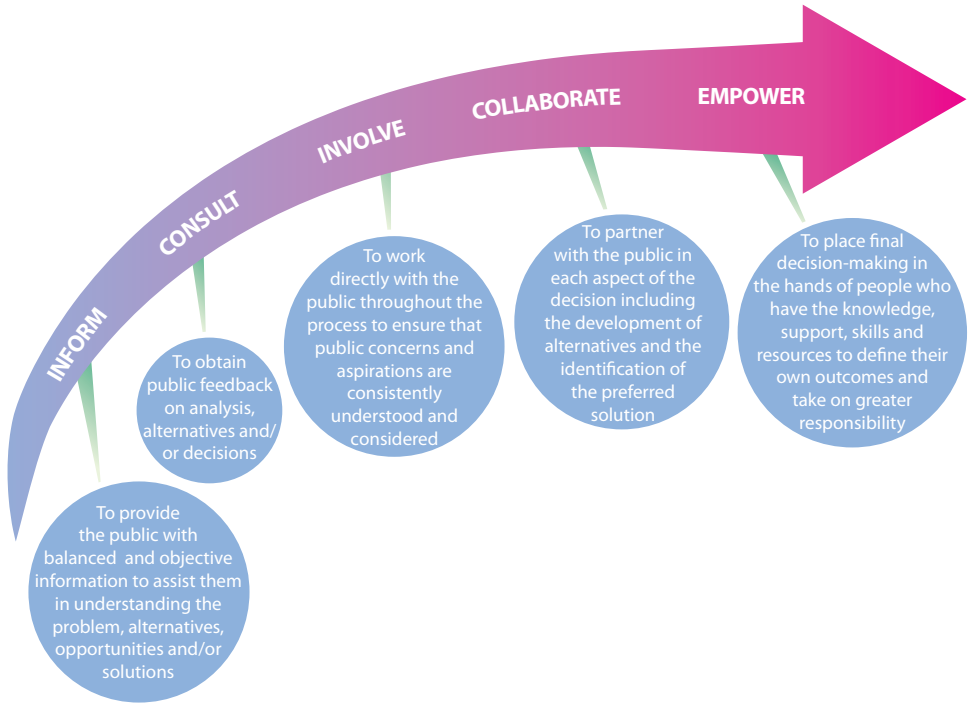
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<sup>45</sup> For more information about this approach, see <http://www.olmsystems.com/news/power-three-saving-significant-amounts-money-health-and-social-care> [accessed February 2016].

<sup>46</sup> See OECD (2016), *OECD Reviews of Health Care Quality, United Kingdom: Raising Standards*.

<sup>47</sup> Dixon, N. (2015), *Stockport Together and People-Powered Health*.

<sup>48</sup> Adapted from Involve (2005), *People and Participation*; International Association for Public Participation, [iap2canada.ca/page-1020549](http://iap2canada.ca/page-1020549) [accessed February 2016].

**FIGURE 10** FIVE STEPS ON AN ARC OF CITIZEN ENGAGEMENT

Taking a more strategic approach to building in people's voice requires partners to develop locality-based care informed by local population needs and geared towards identifying and strengthening community capacity. For example, the Stockport Together programme is taking a collective approach to growing community capacity and social action (see Case Study 1) focussed around two high level outcomes shared by partners: 'people are able to make informed choices and look after themselves' and 'ensuring people who need support get it'. Innovative community-led health in Cleveland, Ohio, emphasises that engagement should be the starting point of any health initiative to work with the grain of people's own needs and aspirations for their health (see Case Study 2). Additionally, All Together Better Sunderland is aiming to help individuals become more empowered to help themselves (see Annex 1).

## CASE STUDY 1 STOCKPORT TOGETHER<sup>49</sup>

Stockport Together is a Vanguard site of integrated health and care services designed to wrap provision around the individual and to empower greater self-management of care. Partners include two foundation trusts, the council, a CCG, the local GP federation and the third sector. At its core, alongside developing the New Care Model, it seeks to grow peer support and social action, encouraging activated citizens to come together to help make communities ‘kinder’ and more connected.

The approach involves a new way of commissioning services from the voluntary sector, using alliance contracting and outcomes-based commissioning around three main aims: to reduce the need for formal care and health provision by strategically targeting those most in need of support; to build greater capacity within the community and the VCS; to create a more joined-up and collaborative system of preventative support within communities where providers work closely with them. There is a focus on growing social action which is locality-based, for example through developing neighbourhood community hubs using existing settings such as cafes which people already use and are trusted spaces, from which to start a different conversation about wellbeing.

## CASE STUDY 2 COMMUNITY-LED HEALTH IN CLEVELAND<sup>50</sup>

The healthcare system in Cleveland, Ohio, previously provided services for the area as if it were a unified community. In reality, it was divided into three neighbourhoods of demographically distinct communities with different capacities to receive health services; the average life expectancy of an inner-city resident was 15 years lower than that of an individual living just a mile away in the suburbs. To

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<sup>49</sup> Dixon, N. (2015), *Stockport Together and People-Powered Health*.

<sup>50</sup> Gavin, V. R. et al (2015), *If We Build It, We Will Come: A Model for Community-Led Change to Transform Neighborhood Conditions to Support Healthy Eating and Active Living*.

respond to this, in 2010 a local health funder established the Francis H. Beam Community Health Fellowship. The goal was to develop a community-led, community-implemented model of promoting healthy living at the hyper-local level. While a state-led initiative would have focussed on achieving expert-recommended, isolated goals such as reducing childhood obesity rates, the model of local engagement was developed by the fellow enabled residents to articulate their own, all-encompassing vision for the future that reflected local circumstances and needs. Over the course of two years, a community-led consultation process succeeded in engaging with 15 per cent of the focus population on how to infuse healthy eating and active living into their local culture, producing tangible benefits for the local community.

Increasing people's empowerment must go hand in hand with a focus on generating deeper insight into how places enable or prevent good health.

## **BUILDING INSIGHT INTO PLACES**

We found that places are developing new approaches to understanding how non-clinical resources and the quality of the built environment can impact on individuals' health. In Sunderland for example, it was understood that planning decisions had led to a concentration of hostels which created problems by concentrating and encouraging dependent and addictive behaviour. The city council's public health team has mapped community interaction points where health conversations can happen and is ensuring the frontline staff are trained in behavioural techniques to maximise positive health decisions. For example, by identifying when and where newly pregnant women get in touch with the system, such as a pharmacist or a receptionist before a doctor, the team could better determine where and how to identify if smoking cessation advice is needed and to use 'nudge' techniques to maximise the impact of that first conversation.

Expertise from elected members, the local VCS, schools, housing providers, local businesses, fire safety teams and people themselves can be used to gather intelligence and understand what resource exists in social and neighbourhood networks, and how it can be activated to support better



health. This approach is used by POC Zero in Birmingham (see Annex 1) through which all partners contribute to mapping community assets and analysing health trends of different groups within communities in order to convene appropriate starting points for healthy conversations and tailor services.

Based on this understanding of places, more detailed mapping of relative and unplanned spend in a neighbourhood or amongst a particular group of people can then begin to uncover what cost pressures might be building up. This can contribute to an understanding that clinical presentations can be caused by wider determinants and so can inform how particular service interventions could more effectively reduce demand within the whole system. The Sustainability and Transformation Planning (STP) process led by NHS bodies locally is an opportunity to build in people's engagement and insight from places more fundamentally into service redesign. But to do this effectively the process must have regard to existing 'place' boundaries such as local democratic or functional economic areas. To inform transformation at the scale needed on an ongoing basis, all local public service partners must commit to sharing data as standard practice.

## **USING DATA TO SUPPORT PLACE-BASED HEALTH**

Appropriate and effective use of data is central to developing insight into people, both on an individual and a whole place population level. On an individual level, the entirety of a person's health experience, and the interaction with their employment, housing and other life circumstances cannot be understood without information being shared between services. Evidence to the Commission ranged from those who cited difficulties experienced in sharing data due to legislation and the need to develop local data-sharing agreements, as demonstrated in Sunderland's work on intelligence using Palantir Technologies system which does not include health data (Case Study 3). Others felt it should be possible but required a workaround. Mobile and personal health technology is also on the rise, creating new, asset based data that citizens not only own but utilise themselves.

## CASE STUDY 3 INDIVIDUAL LEVEL DATA, INTELLIGENCE SERVICE, SUNDERLAND CITY COUNCIL<sup>51</sup>

Sunderland City Council are using their Intelligence System to map and visualise key information about a person by collating datasets from a range of partners; for example the police, the youth offending team, the biggest registered social landlord in the area, schools and the council. This presents a holistic picture of an individual's interaction with different public services onto a single platform, including linking together family or household data, thereby allowing better assessment of need, improved decision-making and more efficient tailoring of services. The missing link to the data system is the lack of permission to input health data due to issues of data protection and confidentiality. The longer-term aspiration is to predict what might happen in the future and provide more preventative services based on these forecasts.

Sunderland City Council is working with their strategic partner, Palantir, to develop the intelligence approach across the council, with the council recently investing in a data scientist resource for the city, to support the embedding of the approach across the city.

Place-based health requires institutions to work for people, not the other way around, and so all health, care and other partners such as housing providers, schools, the police and Job Centre Plus, need to develop clear data-sharing protocols and practice. Data should not be shared as an end in itself, but to meet clear objectives to generate better health outcomes for people. Figure 11 sets out six steps towards putting this into practice, and is based on the experience of health partners in Coventry who have procured a single patient record case management system (Case Study 4) which they intend to roll out to all health and care practitioners locally. This, along with the evidence from GM Connect (Case Study 5), demonstrates that data sharing agreements and governance principles can be forged – the technology exists – but to achieve them requires collaborative and determined effort on the part of all practitioners involved. Where it is happening, it is on a relatively small scale with limited partners. The challenge is to widen these shared protocols across all public services in a place.

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<sup>51</sup> See Annex 1.

**FIGURE 11** SIX STEPS TOWARDS SHARING DATA LOCALLY<sup>52</sup>

Strategic-level data sharing agreements need to filter down to the operational level, where hesitancy may persist among staff who are unclear about the legalities, or concerned about the consequences of inappropriate use.<sup>53</sup> At a national level, guidance has helped to clarify what data can be shared and on what terms.<sup>54</sup> A further step would be to develop model data-sharing agreements between partner representative bodies which local practitioners could adopt and amend.

## CASE STUDY 4 SINGLE CASE MANAGEMENT SYSTEM, COVENTRY<sup>55</sup>

In Coventry the CCG and the council have procured a single case management system covering the whole of the 485,000 population.

<sup>52</sup> Adapted from data sharing practice in Coventry.

<sup>53</sup> CIPFA (2015), *Let's Get Together: Integrating Health and Social Care*.

<sup>54</sup> Information Commissioner's Office Code of Practice, available at <https://ico.org.uk/for-organisations/guide-to-data-protection/data-sharing/> [accessed February 2016].

<sup>55</sup> Based on information provided by Coventry City Council.

This will allow primary care data in the form of patient records to be seen and shared by the primary care service, including all 76 GP practices, out-of-hours GPs, the A&E department and the hospital frailty support team which includes social care workers. The system brings all existing computer systems together and enables sharing with patient consent or in the case of emergencies.

In the first instance local health partners, including GPs practices, the local medical committee, NHS England and the local Healthwatch, devised a set of data sharing agreements which clarified the terms upon which data was to be shared and used. The scheme was also discussed at the Health and Wellbeing Board and went to the Health Scrutiny Board. The next step is to extend the single case management system so that it replaces all computer systems for these organisations.

## CASE STUDY 5 GM-CONNECT, GREATER MANCHESTER INFORMATION GOVERNANCE<sup>56</sup>

Supporting the achievement of their devolution and reform ambitions, Greater Manchester is investing in the development of GM-Connect, a data sharing and governance structure focussed on enabling information sharing across all public sector organisations in Greater Manchester. The development of GM-Connect is based on the acknowledgement that a lack of data sharing is a barrier to collaboration across the public sector and reaffirms organisational silos.

GM-Connect is underpinned by twelve strategic principles, including assigning clear accountability, ensuring a person-centred approach to service delivery, focussing on outcomes, value and impact, and minimising duplication. GM-Connect will be focussed on supporting organisations to access and make effective use of population-level data and map assets within a community, as well as utilise individual and family data where appropriate to do so to help shape integrated packages of support. GM-Connect will also build Greater Manchester's analytical capacity, establishing trends, identifying previously undetected patterns, mapping relationships, and testing

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<sup>56</sup> Lloyd, T. (2016), *GM-Connect: Greater Manchester's Strategic Data Sharing Initiative*.

scenarios in the context of the individual, family, and place. For the service user, GM is moving towards a policy of 'tell us once' across all public services, minimising duplication and improving service delivery. A governance and delivery framework will be established to provide leadership and cross-sector support.

On a 'whole place' population level, more effective data gathering mechanisms need to be in place to track health outcomes and produce robust risk stratification between cohort groups that can inform service planning. Insight into the health needs of a local population is a precondition for developing effective service models that can address demand and seek to reduce it over time. We found that this was being pursued in some areas. For example, the early adopter sites in Suffolk localities (see Annex 1) are being informed by an understanding of cohorts of health needs based on robust population level data and data analysts are developing key outcome metrics to inform planning.

Where population-level data is being gathered, for example to inform joint strategic needs assessments (JSNAs), the potential for its impact needs to move from being descriptive to being predictive. This already occurs through big retail companies' use of consumer data to both track trends and provide a personally tailored future offer based on past customer habits. Whole population data insights must contribute directly to building a robust evidence base from which to redesign services.

## OVERCOMING THE EVIDENCE PARADOX

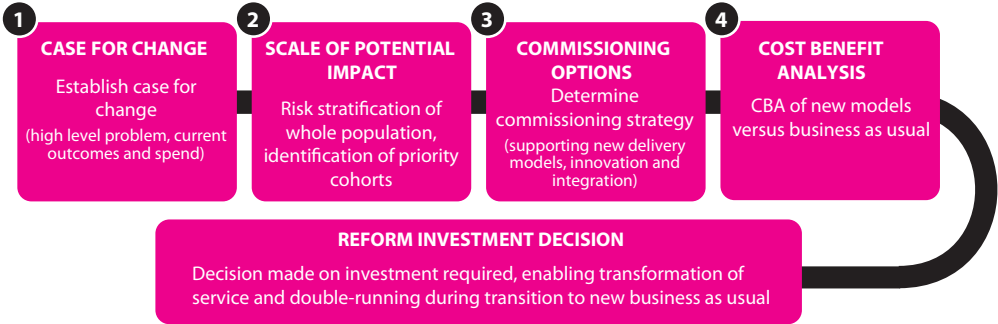
The phases described in this shift all contribute to developing a more solid understanding of the health characteristics of people and places. This is a prerequisite to developing shared outcomes for places, which need to drive planning and investment in a system redesign that shifts power from institutions to people.

At present, stasis in the system is perpetuated by an evidence paradox whereby a lack of good data about the benefits of prevention becomes a reason not to implement reforms which would generate that evidence. Health and local government partners need to make shared investment in a new outcomes model stack up by generating evidence and embedding reform as they go.

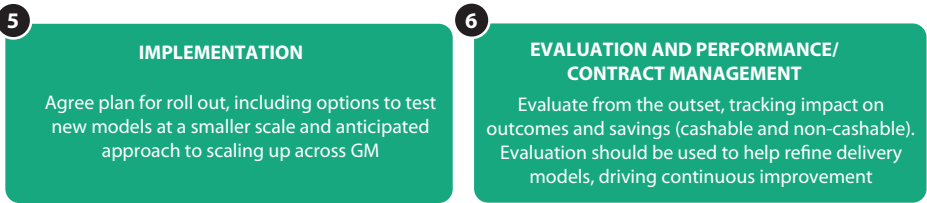
Where progress in overcoming the evidence paradox is being made, local partners are developing business cases for investment based on an agreed problem, targeted cohorts, co-designed outcomes and clear design principles. A cost-benefit analysis is run on the basis of projected benefit from a new delivery model versus business as usual, tested on a small pilot initially to minimise risk. After an evaluation of impact is carried out, the approach can be scaled up. Figure 12 demonstrates the stages of this business case development.

**FIGURE 12** GREATER MANCHESTER REFORM: INVESTMENT APPROACH<sup>57</sup>

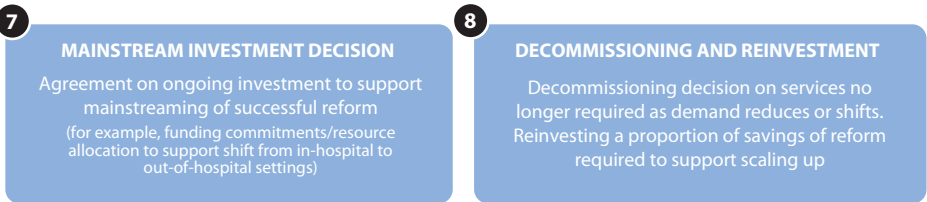
**STAGE 1: PROPOSITION TO INVESTMENT DECISION**



**STAGE 2: IMPLEMENT, TEST, REFINE SOLUTION**



**STAGE 3: MAINSTREAM SUCCESSFUL REFORM**



<sup>57</sup> Information provided by the Greater Manchester Combined Authority.

We found that putting mechanisms in place for evaluation and agreeing metrics for success was in the early stages in some places, and absent in many others. There are examples of cost benefit analysis models being developed by some authorities, housing associations and the voluntary sector (see Case Studies 6), and evidence from international case studies that new ways of working can reduce demand and costs (See Case Studies 7).

To build the confidence of all partners required to invest upfront, localities themselves need to develop and agree their own approaches. These need to be based on agreements over measurements relating to how defined interventions such as intensive care support will impact on demand reduction in hospital admissions. This requires specialist expertise, and it is something that NHS England should provide support around, with local government playing a greater role alongside health in randomised control trials.

We are encouraged to hear that Public Health England and the Chartered Institute for Public Finance Accountancy (CIPFA) are working to create a set of professional standards for creating place-based business cases for investment in prevention and early intervention – a way of both de-risking the process for local leaders, and building investor and central government confidence in its credibility. This will need to address the very real implementation challenges of realising benefits in practice and partners that didn't invent the methods are still encouraged to nonetheless develop ownership of the new approach.

Ultimately, service redesign must re-adjust the balance between hospitals and community-based services or at-home provision. It is not feasible to reduce the former without building up the latter concurrently. Alternative place-based architecture will need to emerge that can break the institutional grip of the hospital-based model of care, and be better linked into supporting the natural assets of people and places instead.

## CASE STUDIES 6

### EVIDENCE OF COST-BENEFIT ANALYSES

The Commission found several business cases for investment being developed by a range of local authorities, housing providers and the VCS. These were based on cost benefit analyses projecting cost reductions and outcome improvements. They will not necessarily result in realisable savings unless invest and save budgets are aligned over a longer time period. They are therefore indicative of the approach local partners need to agree and invest in together.

#### GREATER MANCHESTER LOCALITIES<sup>58</sup>

- Extra Care Housing in Wigan and Manchester for over 55s at risk of admission to either hospitals or social care. Investment requirement is between £13k and £15k per place, generating between £1.09 and £1.52 in benefits per £1 invested over five years.
- Wigan's The Deal programme provides evidence to support a Community Asset based programme and shows how investment of around £1,900 per person could generate benefits of £1.95 per £1 invested per person over 5 years.

#### FAMILY MOSAIC, HEALTH BEGINS AT HOME RANDOMISED CONTROLLED TRIAL<sup>59</sup>

In partnership with the London School of Economics, the housing association Family Mosaic self-funded and trialled a health and wellbeing service for tenants over the age of 50, most with one or more long-term condition. The 18 month trial ran for three groups: a control group, a second group supported by a neighbourhood manager to signpost tenants onto health and wellbeing services; and a third group supported by a dedicated health and wellbeing support

<sup>58</sup> Based on information provided by Manchester and Wigan localities.

<sup>59</sup> Family Mosaic (2016), *Health Begins at Home: Final Report*.



worker who received intensive personalised support. Interventions for the second group resulted in an estimated reduction in NHS usage by £1.58 million per year and £3.4 million per year for the third group.

## TURNING POINT'S CONNECTED CARE MODEL<sup>60</sup>

Independent cost-benefit analysis of Turning Point's Community Navigator pilots – which supported local residents in deprived neighbourhoods in Birmingham – was based on five cases and demonstrated a net cost improvement of between £1,956.86 and £9,812.73 per person depending on need. The majority of the savings were attributed to the local authority through benefits from secured tenancies, improved personal care, fewer missed appointments and reduction of falls at home.

## PIONEER PROGRAMME: CORNWALL AND ISLES OF SCILLY<sup>61</sup>

The Living Well Programme is a partnership of the NHS, Cornwall Council and VCS to co-design and co-produce an innovative combination of medical and non-medical support based on goals that the elderly person identifies as most important to them. The programme ran for a year from January 2014 and a matched cohort evaluation found:

- 20 per cent improvement in wellbeing
- 41 per cent reduction in acute hospital costs
- 8 per cent reduction in social care costs
- 28 per cent reduction in community hospital inpatient activity
- 20 per cent reduction in community hospital length of stay
- 34 per cent reduction in emergency admissions
- 32 per cent reduction in hospital admissions overall.

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<sup>60</sup> Turning Point (2016), *Connected Care Model Evaluation*.

<sup>61</sup> NHS England (2016), *People Helping People: Year Two of the Pioneer Programme*.

## LGA ANALYSIS WITH NEWTON EUROPE<sup>62</sup>

The LGA ran financial modelling on potential efficiency savings in a few participating areas. Evidence generated suggested that overall savings of seven to nine per cent savings of the budget areas assessed could be realised through efficiency savings.

- 30 per cent of ‘avoidable hospital admissions’ which could be prevented by early identification.
- 14 per cent of people admitted to hospital for acute care could have avoided this through both primary and community services; and around eight per cent of individuals could have had their admission avoided by better use of social care services.
- 22 per cent of non-elective beds in the acute hospital could be freed up by using alternate settings of care – predominantly at home with social care support or community services.
- For 21 per cent of the people who were discharged from hospital onto pathways involving a package of care, a preferable pathway was identifiable that could have delivered better outcomes for the service user at lower cost.

## CASE STUDIES 7 INTERNATIONAL EVIDENCE

### THE GESUNDES KINZIGTAL MODEL<sup>63</sup>

A partnership developed in the mid-2000s between a network of Southwest German physicians and a management company. The *Gesundes Kinzigtal Model* is a regional integrated care management company, set up to provide better, more efficient care for the local population. *Gesundes Kinzigtal GmbH* holds “virtual accountability”

<sup>62</sup> LGA (2011), *Efficiency Opportunities through Health and Social Care Integration*.

<sup>63</sup> The King’s Fund (2015), *Population Health Systems*.

for the healthcare budget for the population group and negotiates cooperation contracts with a range of local providers who have agreed to adhere to a set of guiding principles, standards and procedures.

In 2012, the model generated around a 7 per cent saving against the population budget for members of one of the sickness funds (against a matched cohort evaluation), which equated to a saving of €4.6 million for the 31,000 affiliated members in the Kinzigtal region. Reduced emergency hospital admissions are an important contributor to this saving: between 2005 and 2010, emergency hospital admissions increased by 10.2 per cent for patients in Kinzigtal, compared with a 33.1 per cent increase in the comparator group.

## SKAEVINGE PROJECT, DENMARK<sup>64</sup>

An integrated nursing home and home care service, the Skaevinge project in Denmark focusses on prevention and self-care for elderly patients. After ten years, the pilot had halved the average number of bed days per patient from six to three and delivered cost savings of 21.6 per cent in net expenditure on elderly care in the municipality.

## BUURTZORG MODEL, NETHERLANDS<sup>65</sup>

An integrated team of nurses, primary carers, the individual and their family provide care and support packages tailored to individual needs and, crucially, within their own homes. Although this results in higher costs per hour because of the intensive work undertaken by the nurses, it also results in a lower number of hours in total. An Ernst and Young evaluation found that as a result the model created 40 per cent savings to the Dutch healthcare system.

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<sup>64</sup> Royal College of Nursing (2013), *Moving Care to the Community: An International Perspective*.

<sup>65</sup> The History of Buurtzorg, available at <http://buurtzorgusa.org/about.html> [accessed January 2016].

## RECOMMENDATIONS FOR SHIFT ONE

In order to turn high level strategy into practical action on prevention and shift power from institutions to people and places, the Commission proposes immediate action:

### EMPOWERING PEOPLE

- All clinical and care professionals should recognise and promote the use of individual personal care plans, so that all professionals work to their expressed outcomes, and work with partners to develop social prescribing to better connect people to community resources.
- Commissioners should encourage collaboration through methods such as alliance contracting which embed a common approach and develop asset-based models which work with, rather than separate from, existing social capital and potentially generate social value.
- Local health bodies should be charged by NHS England and Health Arm's Length Bodies with producing Sustainability and Transformation Plans (STPs), which should actively engage local people in their development by creating opportunities for them to co-design the planning. They should co-produce these plans with health and wellbeing boards and wider local government, in order to address the Five Year Forward View 'three gaps' (health and wellbeing; care and quality; and finance and efficiency). All local partners should use the opportunity to develop a strategic collective approach to identifying community capacity and building social action, with clear actions and plans agreed to achieve this.
- As integration develops, health and care partners should develop a single communications process with a shared narrative across a place, both for people in communities to empower and motivate them through accessible mediums such as social media, and for the workforce to ensure a consistent approach to individual empowerment.

## DEVELOPING INSIGHT INTO PLACES

- STP 'footprints' should have regard to – and where possible align with – local democratic boundaries and functional economic areas to enable health and wellbeing boards to interface effectively.
- Local government and CCGs should work together to map community assets and interaction points, and identify unplanned spending pressures in the locality in order to plan service interventions more effectively. Partners can immediately take advantage of the STP process to utilise this approach at scale.

## USING DATA TO SUPPORT PLACE-BASED HEALTH

- Local partners including health, local government and other local public service partners such as schools, police and housing providers should develop data sharing protocols.
- NHS England should lead work with the Office of the Information Commissioner and partner representative bodies (of GPs, local government and other local public services) to develop model data-sharing agreements which local partners can adopt and amend.

## OVERCOMING THE EVIDENCE PARADOX

- Local government and health partners, including acute and primary care, should develop shared outcomes based on population intelligence and insight into people and places. They need to develop agreed metrics and methods of evaluation which should underpin business cases for shared investment in new outcomes models.
- Local government should play a greater role in randomised control trials alongside health partners to demonstrate demand reduction.

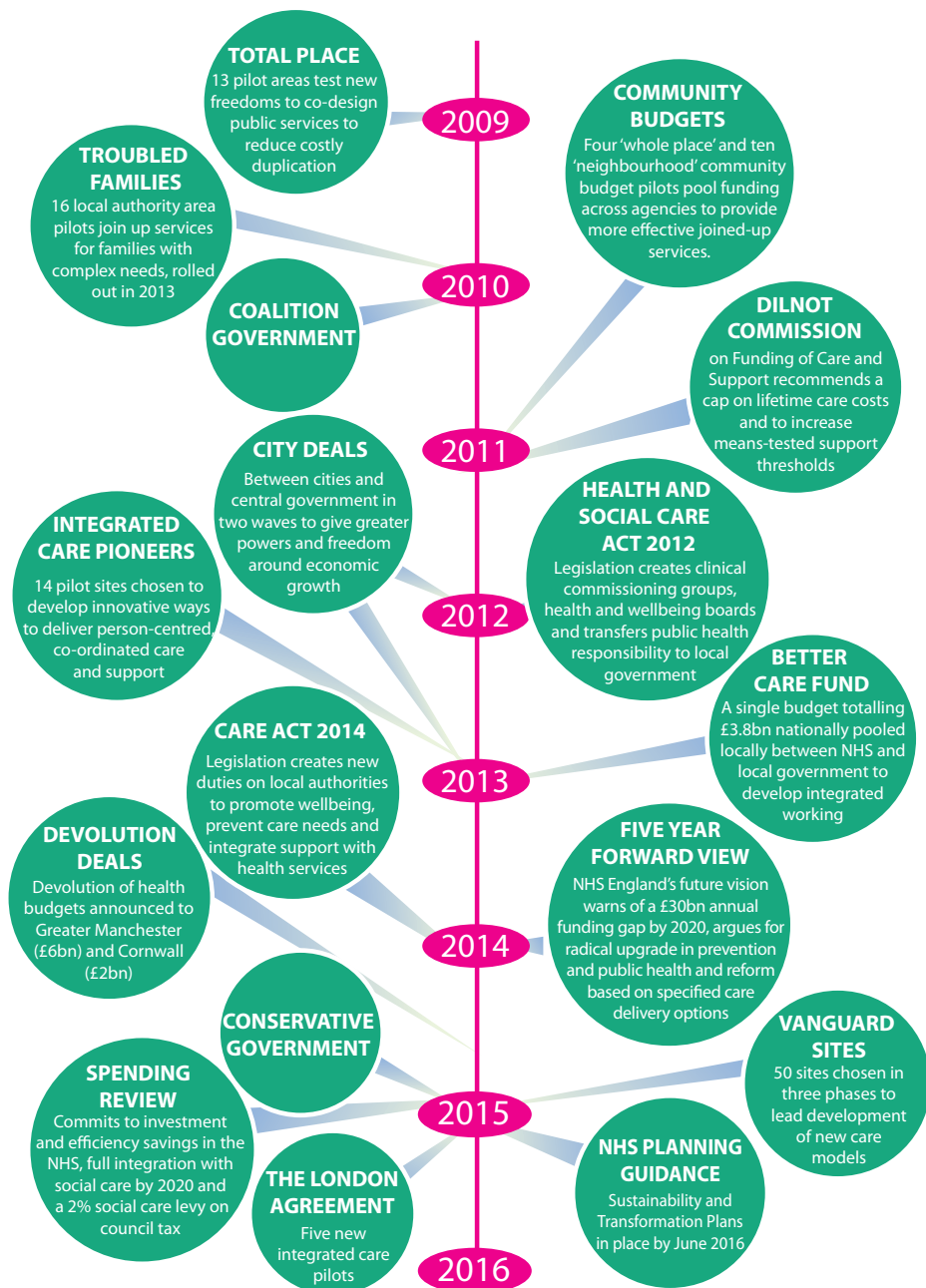
A focus on infrastructure alone will not create the transformation required – the culture and relationships at the heart of them are vital to understand, which Shift Two will explore in more detail.

# SHIFT TWO: FROM SERVICE SILOS TO SYSTEMS OUTCOMES

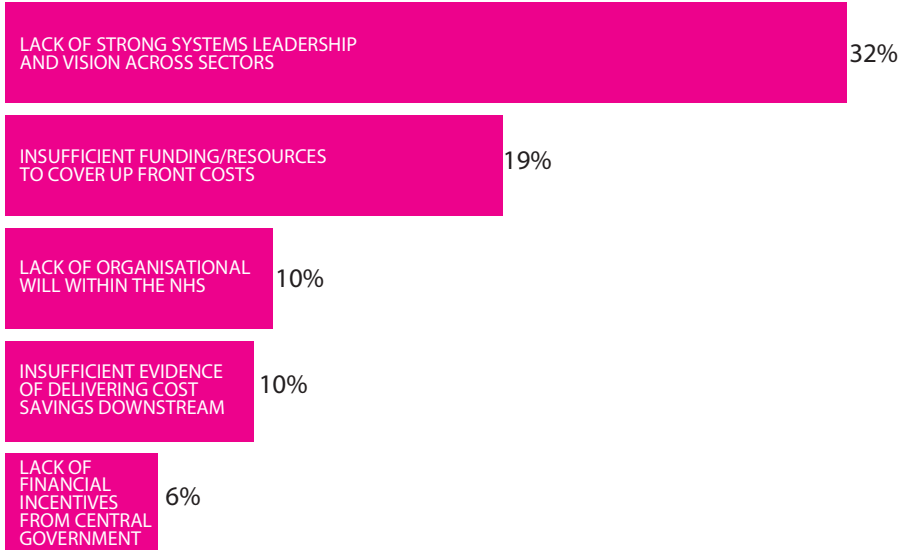
**Separate services are currently set up to work to their own organisational priorities. Moving from the dominance of vertical silos of “health” and “care” to horizontal place-based systems will involve cultural and behavioural change on a completely new scale. Enablers of this change need to be recognised, developed and supported at every level, to then lead the creation of a new system from the inside out.**

The focus of national policy initiatives (see Figure 13) for the past few decades has been on the creation of new organisational structures. We have seen several different permutations of commissioning, culminating in the Health and Social Care Act 2012. Since then we have seen something of a shift towards place and planning driven by NHS England and emphasised by the Vanguards. This change in direction is promising, but if it is to succeed in transforming the health, care and wellbeing system then we need better local leadership. Our survey respondents cited this as the biggest barrier to change, even more so than a lack of financial resource or evidence of future cost savings (Figure 14).

As the Commission examined practice in Birmingham, Suffolk, Sunderland and Sutton, it became clear that two elements were integral to creating place-based systems: the existence of systems translators and the use of commitment devices. The value of each to effective systems leadership and development needs to be understood, identified and encouraged for new ways of working to endure. The role of health and wellbeing boards also needs to be developed so that they become more effective forums for systems leadership.

**FIGURE 13** TIMELINE TOWARDS PLACE-BASED HEALTH

## FIGURE 14 WHAT IS THE TOP CHALLENGE TO IMPLEMENTING EARLY INTERVENTION AND PREVENTION INITIATIVES IN YOUR AREA?



## SYSTEM TRANSLATORS

Both health and local government workers accept that they speak different languages, to the point where they sometimes struggle to understand one another. Different specialisms, accountabilities, funding mechanisms and organisational models manifest themselves in different ways of operating on a day-to-day basis. Lack of understanding leads to lack of trust and scepticism of the benefits each would bring to a partnership.

This point is neatly illustrated by two quotes from our research:

*“Health are more forward-thinking and more proactive than local authorities”*

Healthcare provider

*“The NHS tends to look upward not outward”*

Local authority representative



We found that the role of ‘system translator’ is significant in bridging the divide. These are individuals, of no specific organisation or level, who are able to talk the language of both “sides”. In one place this was someone in the CCG, in another it was a councillor who was also a GP. These system translators usually, but not always, had career backgrounds that had taken them through different parts of the system. Their common feature was their ability to communicate the benefits of integrated working, build trusted relationships and instil a high degree of confidence from all partners involved. On an ad hoc basis, varying from place to place, it was these individuals who were leading the system change and have the potential to instil new ways of behaving that could set the tone for a more cooperative culture to emerge. This was informally recognised by other people through discussions who cited these individuals as significant in coordinating and galvanising action, and building trust.

System translators are able to overcome the challenges of mutual professional suspicion, residual lack of belief in the ability of reform to bear fruit and the overriding absence of systems leadership. Their unique contribution is to focus their peers on outcomes, creating a shared loyalty to achieving their goal. Their skillset has the potential to proactively forge shared understanding and respect, and work towards agreeing shared outcomes. Developing this theme, key attributes for system translators include that they:

- Are very good at forging relationships and networking
- Have a sense of purpose and can think across boundaries
- Are curious, insightful and empathetic
- Take a positive, proactive and creative approach to problem-solving
- Focus ruthlessly on outcomes

While we saw system translators at work in the context of health and social care integration, it is quite clear that the job of translation is about much more than just getting these two institutions to speak effectively to one another. We also need translation between the public and social sectors, and between all sectors and the public. No one individual can be expected to do all of this, so we are going to need systems translators at all levels of the health, care and wellbeing system. The new local Workforce Advisory

Board set up by Health Education England should promote the role and skillset of system translators as they coordinate workforce requirements for STPs.

## CASE STUDIES 8 SYSTEM TRANSLATING IN PRACTICE

### INTEGRATED NEIGHBOURHOOD TEAM WORKING, SUFFOLK LOCALITIES<sup>66</sup>

The Connect programme is approaching the cultural divide between the partner organisations of their Integrated Neighbourhood Teams (INTs) through fostering a greater understanding of what each other does. The INTs include professionals from health, social care, the police, mental health and the voluntary sector. They have taken various steps towards this: they created a shared directory; set up a workplace shadowing scheme; created a life timeline tool which mapped when key interventions are likely to take place from cradle to grave; they set up lunch and learn talks with 'demystifying sessions' for different organisations; they developed shared, core INT principles; and, where possible, co-located organisations.

### GREATER MANCHESTER COLLABORATIVE LEADERSHIP FRAMEWORK<sup>67</sup>

The Greater Manchester Combined Authority is currently developing a place-based collaborative leadership framework. This framework cuts across organisational boundaries, focussing on the skills and approach needed to lead a place rather than an organisation. Greater Manchester recognised the need for system leaders rather than siloed service leaders in order to deliver their systems-wide reform programme. The collaborative leadership framework will be used to support the wider Greater Manchester strategy of economic

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<sup>66</sup> See Annex 1.

<sup>67</sup> More information available at <http://publicservicetransformation.org/resources/collaborative-leadership/917-developing-place-based-collaborative-leadership-greater-manchester-combined-authority> [accessed January 2016].

growth and public service reform. The framework will develop a common language across a place in order to build up shared skills and ambitions across different organisations, workforces and leaders. This will be supported by ongoing personal and professional development, tailored to individual leaders' specific needs.

Despite the vital importance of system translators to service integration – and the fact that these skills are increasingly recognised as vital for the future workforce – the public sector is still not doing enough to train, develop and support this kind of person. Translators often come into integration projects by happy accident, rather than because NHS or local government leaders actively cultivate them or seek them out. But if they move on, steps towards integration might be easily compromised as a result.

There are a number of practical recommendations that can encourage and embed this skillset more widely:

- Prioritise and make time for job-swapping opportunities between partner organisations
- Identify the skillset associated with system translators and embed these into core competencies and through performance management
- Make education and training premised upon recognising and developing this role
- Create more flexibility in job roles beyond core specialisms to work to outcomes beyond the immediate organisational remit
- Include these roles within wider workforce planning and recruitment
- Create opportunities for wider workforce teams to engage with each other, work through issues and discuss what integration means in practice

Developing and embedding role of system translation has potential to lead a wider shift from siloed to systems working. Beyond that transition there is a continued need for this role to be recognised and rewarded in terms of the system interfacing with people themselves, and ensuring it is constantly challenged to be accessible and accountable to the people who use services. Currently some public health teams or community connectors (and similar job-specific roles) can be identified as possessing this skillset and performing this function: in a place-based health system all professionals need to.

## COMMITMENT DEVICES

The same integration initiatives have had variable impacts in different places. In some areas, the Better Care Fund has catalysed reform, partners have committed more funds than required and the measure is galvanising new ways of working. In other areas, it has been side-lined. Similarly in both Cornwall and Greater Manchester, devolved health budgets are providing a focus for new governance and service models across the place, but elsewhere there is no appetite for such a radical measure. It can be similarly expected that the new STP requirements will galvanise action in some areas and create friction in others.

Our research generated insights into how and why these same initiatives would have differing impacts. Devolved, pooled and fully integrated arrangements are all forms of “commitment devices”. If they are deployed at the right time by partners based on good relationships and along a trajectory towards integration, they can serve to deepen and embed it.

Commitment devices are many and varied: they can be as small as simply agreeing joint objectives or jointly funding a shared post, through to setting joint outcomes and using market mechanisms as a lever to drive collaboration. Their unifying feature is that they are all outcome-focussed, and to varying degrees involve partners giving something up and adopting something new. Figure 15 identifies some examples on a spectrum from light touch collaboration through to full integration.

**FIGURE 15** SPECTRUM OF COMMITMENT DEVICES



The point at which commitment devices are deployed across the health and care system is critical. Use them too soon and you create friction if solid relationships are not yet in place and partners do not yet trust each other's motives. This has arguably been the experience that some areas have had with the Better Care Fund. Yet without any commitment devices at all, partnerships tend to get beached at the bottom end of the scale, having meetings that lead nowhere and maintaining separate ways of working despite the appearance of good relationships.

We support those commissioners who are looking to encourage provider collaboration through methods such as alliance contracting, collaborative commissioning, and extending the principle of personal care plans to drive a focus beyond clinical services.

## CASE STUDIES 9 COMMITMENT DEVICES IN PRACTICE

### CONTRACTUAL – TENDER FOR SEXUAL HEALTH SERVICES, BIRMINGHAM<sup>68</sup>

The competitive tendering process in Birmingham encouraged collaborative working between organisations to win the contract to provide a sexual health pathway for the population of Birmingham. It also provided the opportunity for an outcome-based specification which focussed on prevention. This resulted in the complete redesign of how services are provided to the public with greater emphasis on, and incentives for, prevention. Organisations including pharmacists, charities and GPs came together under a bid led by University Hospital Birmingham to deliver sexual health services in contract to public health at Birmingham City Council. The pathway operates under the name 'Umbrella' and is a five-year contract worth £83 million with the first two years payable as a block contract before moving to outcome-based payments.

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<sup>68</sup> See Annex 1.

## JOINTLY FUNDED POSTS – INTEGRATED NEIGHBOURHOOD TEAMS, SUFFOLK<sup>69</sup>

The Integrated Neighbourhood Teams in Suffolk are inter-disciplinary across health, social care, the police, mental health and the voluntary sector. The teams work together on the Connect pilots, providing a holistic team around the individuals in the pilot areas, but they are ultimately funded, regulated and accountable to their host organisations.

## FINANCIAL – JOINT COMMISSIONING, SUTTON<sup>70</sup>

Traditionally the CCG commissioned for mental health care in silos, based on separate conditions. The Sutton Uplift project has moved towards a model of a single point of access in health and social care to assess all needs in one go and provide holistic support around the person. This project was designed by the joint commissioners of mental health and learning disabilities within the CCG, where funds across mental health and learning disabilities are pooled.

Health and care partners need to develop a clear understanding of the moving trajectory towards integration, properly articulated and encouraged by system translators, and the role various commitment devices can play in cementing new ways of working along the way. At each stage, a new commitment device can deepen relationships by requiring all sides to put something on the table, and gradually leave past practices behind.

## MAKING A LONGER-TERM SYSTEM SHIFT TOWARDS WELLBEING

Who can oversee and guide the establishment of our enablers within the system? Health and wellbeing boards (HWBs) were designed to play this role, but in practice they have been highly variable in their performance and capacity to drive change.<sup>71</sup> One Commissioner said that HWBs were:

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<sup>69</sup> See Annex 1.

<sup>70</sup> See Annex 1.

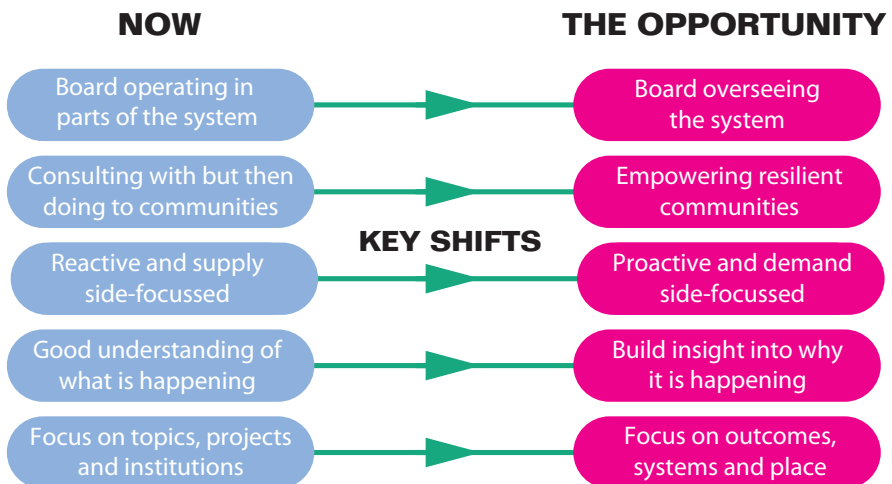
<sup>71</sup> The King's Fund (2013), *Health and Wellbeing Boards: One Year On*.

*"... the right idea but wrong execution because they are inward-focussed and not addressing the right topics."*

HWBs should be leading the conversation about health and wellbeing in a place. They should play an active role in identifying and bringing together key stakeholders to forge a vision for a place, including those beyond the direct health and local government spheres such as business, the VCS, community pharmacies, housing associations, schools, Jobcentre Plus and people themselves.

When they assumed their role in 2012, the primary focus of health and wellbeing boards was to bring together partners with a focus on tactical actions and performance improvement. As they progress they should move towards a systems approach to accountability, bringing together systems leaders to become more mature, iterative and collaborative in their focus. Figure 16 outlines some key shifts for health and wellbeing boards in their transition to being a forum for effective systems leaders.

**FIGURE 16** KEY SHIFTS FOR HEALTH AND WELLBEING BOARDS<sup>72</sup>



<sup>72</sup> Adapted from Coventry Health and Wellbeing Board.

## RECOMMENDATIONS FOR SHIFT TWO

To make the shift from service silos to systems outcomes, professionals in places need to take immediate steps to pursue the following actions:

### EMBEDDING SYSTEM TRANSLATORS AND USING COMMITMENT DEVICES

- Commissioners and management teams within all organisations need to recognise, reward and encourage systems translators through workforce planning, training and development. The new local Workforce Advisory Board set up by Health Education England to promote the role and skillset of system translators as they coordinate workforce requirements for STP ‘footprints’.
- Health and local authority partners need to understand and use commitment devices as part of a trajectory towards integrated working. For example, by identifying progress to date they can set out what have been used already, what commitment devices could potentially be used and agreeing a timeframe through which to deploy stronger devices.
- The role of system translators and the use of commitment devices should be recognised as STPs are being developed, especially where new relationships are being forged quickly to meet the timescales set out by NHS England. Rather than just mandating structural change, NHS England should support the development of cultural and behavioural norms as conducive to sustaining reform. For example, an immediate action could be to ensure the single named individual for each STP footprint should be able to demonstrate system translator skills and should receive training in this skillset.

### DEVELOPING HEALTH AND WELLBEING BOARDS AS SYSTEMS LEADERSHIP FORUMS

- HWBs should convene leaders from across the local system including the VCS, social enterprises, housing providers, community pharmacy, education, businesses and the wider community, to devise and work towards shared outcomes.



- HWBs should lead a process of giving health and care workforces the tools, training and above all clear permission from leaders to shift from a service-based approach that 'does to' people to practice which 'works with' people and encourages them to take responsibility for their health.

The agreement of shared outcomes locally then needs to be supported by shared accountability for delivery, and in the next section we turn to the role of the national policy framework to better enable this in practice.

# SHIFT THREE: ENABLING CHANGE FROM NATIONAL TO LOCAL

**Our evidence suggests that place-based health will remain a pipedream unless it is supported by practical and behavioural changes among politicians, professionals and people on the ground. This is a transformation of approach and mind set more than one of simply organisational machinery, but the policy framework still matters. The national environment can facilitate and encourage change, or work against it.**

At present the policy framework is in flux. There are positive movements in the direction of place-based working. For instance, the Five Year Forward View has actively encouraged experimentation and backed this with the Vanguard programme and a substantial transformation fund to support devolution and reform in Greater Manchester. The NHS Planning framework will likely be an enabler of a place-based shift, although the funding accompanying it is geared more towards NHS 'sustainability' than it is system 'transformation'.<sup>73</sup> Sustainability and Transformation Plans (STPs) led by the NHS and defined by clinical rather than democratically accountable or functional economic boundaries might create problems in practice.

These changes are in the right direction, but there is more to do. The final shift the Commission proposes is designed to create a more permissive environment for innovation and transformation, embed long-termism into the system and allow for the system to plan beyond the political cycle. The approach articulates how change over the coming years will need to focus on the three challenges outlined at the beginning of this report: to overcome the evidence paradox; to align organisational and financial incentives; and to flex regulation to enable innovation and scalability. It ends by imagining what a system of place-based health would look like in practice.

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<sup>73</sup> See <https://www.england.nhs.uk/wp-content/uploads/2016/02/sustainability-transformation-plan-letter-160216.pdf>.

## A FIFTEEN YEAR FORWARD VIEW

The Commission proposes a Fifteen Year Forward View setting out the long-term challenges facing existing health, care and wellbeing services and making plans for addressing them. This will immediately strike some readers as being at best naïve and at worst irrelevant. At a time when the NHS is facing such huge operational pressures, why should we focus on a time frame that will take us three parliaments into the future? How could such a plan ever hope to stick?

The truth is that those operational pressures are not a short-term blip. They are symptoms of a far broader set of structural challenges facing the NHS. Today's pressures might be addressed by an injection of new money and some efficiencies, but the challenges of ageing and chronic disease will not stop in 2020. We face a choice between firefighting our way through next few decades, or confronting the generational challenge in a more ambitious way.

The Five Year Forward View (5YFV) was a powerful intervention by NHS England and Health Arm's Length Bodies, focussing minds nationally and locally about the scale of the challenge the health service faces. It moved the debate on by identifying gaps in the present system and a route for reform moving beyond "one size fits all" to embed the principle of New Care Models developed locally. But the challenge the Five Year Forward View seeks to address is, specifically, keeping the NHS viable until 2020. This inevitably limits its horizons.

A 15 Year Forward View (15YFV) would be a very different sort of plan. It would need to clearly analyse the demographic and healthcare challenges facing the system over a long period of time. It would be able to show how preventative investments made today would pay off over a longer time frame. Where short-term cost-benefit analysis might look sceptically at distant projected benefits from prevention and early intervention, it seems clear that a longer view would build a strong case for a system of place-based health. Ultimately, it would force us to start planning today for the kind of health and wellbeing system we want to achieve by the 2030s.

This is not to say we would expect such a plan to be a rigid strategy for the future and fully implemented. Even if today's government accepted

it, the next might not. Indeed, the whole point of the timescale is that the 15YFV would not be limited by today's political possibilities; none of us can know who will occupy Downing Street by the early 2030s. But the very act of looking to the future can be used to inform better challenges today. The 15YFV would be designed to have the impact of a Wanless or Stern Review, using long-run analysis to create a new understanding of an old problem. The 15YFV ought to perform a role analogous to that of the National Infrastructure Commission in taking us towards our future major infrastructure requirements: making the case for a long-term vision which looks beyond today's political cycle but can only ever be implemented if we start now.

The challenges facing our health and care system are generational. The English population will continue to age and the benefits of early intervention with a child born today will take years to emerge. As the experience of reform in Sweden demonstrates (see Case Study 10), the process and payoffs will take many years to become clear. Preventative measures put in place now will realise benefits beyond the next election cycle. It will take political courage and vision to step outside of these cycles to embed this long-term approach and this will have to be run on a 'twin track' basis while it is embedded.

## CASE STUDY 10 SWEDISH HEALTHCARE SYSTEM<sup>74</sup>

In Sweden, councils have been responsible for providing universal health and care services for their populations since the 1970s. 70 per cent of health expenditure is raised through local taxation and hospitals are run or contracted by county and municipal councils, meaning there is an element of democratic accountability in the delivery of health and social care services. Central government sets the national standards and guidelines, and provides 25 per cent of health funding through central block grants.

The Swedish healthcare system has much better health outcomes on a number of indicators compared to OECD averages. Sweden has one of the lowest rates of amenable mortality in the OECD, roughly 25-30% below the OECD average. In 2013, average life expectancy at birth in Sweden reached 82.0 years, 1.5 years longer than the OECD average of 80.5 years.

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<sup>74</sup> OECD (2015), *OECD Reviews of Health Care Quality, Sweden*; Gay et al. (2011), *Mortality Amenable to Health Care in 31 OECD Countries*.

Where the 5YFV was led from NHS England and advocated reaching out beyond organisational boundaries, a 15YFV would need to be led by a broad range of arms' length and representative bodies NHS England, NHS Improvement, Public Health England, Health Education England, Care Quality Commission, NICE, the Local Government Association and beyond. But it would also need to be strongly informed and its shape influenced from the bottom-up. The 15YFV would need to set out reform principles to galvanise all resources in places to prevent diseases, increase life expectancy and promote wellbeing. The focus would be across the whole system to rally around to realise a vision of a place-based, asset-driven approach to individual health and personal responsibility.

The 15YFV is designed to shift existing health, care and wellbeing services' horizons beyond the end of this decade and enable the forging of a wider health and wellbeing system. While we do not want to prejudge the Forward View, there are some actions that should be taken now to lay the groundwork for place-based transformation, and others that we would expect to come under consideration as the Forward View is developed.

## A FIFTEEN-YEAR SCENARIO: WHAT COULD THE FUTURE LOOK LIKE?

There are some actions which we suggest could be undertaken immediately to begin laying the groundwork for the future of place-based health, in the areas of finance and innovation. Some involve initiating new processes, and others involve shaping existing reforms underway to ensure they set in place the conditions for future reform.

### FINANCE:

- **CONTINUE DEVELOPING THE NASCENT CROSS-PARTY AND PUBLIC CONSENSUS ON SUSTAINABLE FUNDING:** We welcome debate about how the country will pay for the costs of ageing. Building on the work of Lord Filkin's 2013 House of Lords Commission,<sup>75</sup> and echoing the calls of Stephen Dorrell, Alan Milburn and Norman Lamb

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<sup>75</sup> House of Lords Select Committee on Public Service and Demographic Change (2013), *Ready for Ageing?*

for a cross-party review into health and social care funding<sup>76</sup> will be essential. Such a debate would almost certainly conclude that we will have to pay more, either through the tax system or out of our own pockets in the private sector. This process should be led by national politicians but will never be accepted unless it engages with wider stakeholders and society.

- **COMMIT TO SHIFTING NEW MONEY TO TRANSFORMATION:** The government should guarantee that a substantial proportion of any new money it may find for the NHS would be designated as a fund to support system transformation, rather than just being spent on managing day-to-day demand.

## INNOVATION:

- **PROMOTE ACTIVE COLLABORATION BETWEEN NHS AND LOCAL PUBLIC SERVICE PARTNERS:** Those framing the NHS-led Sustainability and Transformation Planning processes (whether commissioners or, perhaps in some cases, providers) need to demonstrate that they have genuinely engaged councils and civil society as equals in shaping their work. This means allowing challenge and being prepared to shift direction in response to a shared goals.
- **CONTINUE TO ACCELERATE AND SUPPORT NEW MODELS OF CARE:** NHS England should support the development of new models of care (described in the 5YFV) throughout the country as a matter of urgency, not just in the Vanguard sites.
- **USE NEW LEVERS TO PLAN FOR WHOLE POPULATION HEALTH:** The Spending Review 2015 requirement that all places should have a plan for the integration of local services in place by 2017 and implemented by 2020 should be used to accelerate the shift towards whole population planning for health and wellbeing.
- **CONTINUE TO EXPLORE THE POTENTIAL OF PLACE- AND SYSTEM-BASED GOVERNANCE:** Where devolution deals are in place, elected mayors and combined authorities should be encouraged to

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<sup>76</sup> See BBC (6 January 2016), 'Cross party review needed for health and care', available at <http://www.bbc.co.uk/news/health-35233346> [accessed February 2016].

grasp the nettle of devolved health and social care reform. Small scale cost benefit analysis should develop insight into unplanned spend and support new delivery models. These should, by definition, look different in different areas to address locally-identified priorities.

■ **PROMOTE A WIDER APPROACH TO CULTURE AND BEHAVIOUR**

**CHANGE:** NHS England and the Local Government Association should fund the creation of a national programme to train and promote system translators, embedded through existing STP and integration reforms. This would support joint workforce transformation initiatives currently being planned in different localities.

## ACTIONS BY 2020

We have a further set of actions which we believe need to be completed by 2020 to ensure that the health, care and wellbeing system is put on a solid footing and continues progress towards place-based health:

### FINANCE:

- **EMBED THE FINDINGS OF THE 15 YEAR FORWARD VIEW:** The government should establish a Royal Commission or its equivalent on health, care and wellbeing funding. This should set out a consensus position on the future viability of the system, having regard to the recommendations of the 15YFV.
- **ESTABLISH LONG-TERM BUDGETS AS THE NORM:** Based on the forging of cross-party political consensus, the government of 2020 should introduce multi-year place-based budgets for health, care and wellbeing services for the full life of the Parliament. These should give all local agencies enough financial certainty to be able to invest in transformation projects. This should begin to support the emerging concept of the “local pound” whereby statutory money is focussed to maximum effect based on need and what works, regardless of institution, discipline or history.
- **SINGLE POINT LOCALITY COMMISSIONING FROM ONE HEALTH AND WELLBEING BUDGET:** Government should phase these in by expanding the Better Care Fund into a far larger single health and

wellbeing budget which would be used to transform local services in the direction of place-based health. Where they exist, this budget would be governed at the level of a combined authority by a joint committee of all delivery partners chaired by the mayor. This would embed further the 'local pound' and enable greater integration at scale on devolved footprints between health and wellbeing support and wider place-based services such as employability support, which by this point is likely to be much more accountable to devolved governance.

- **BEGIN DEVELOPING WIDER LOCAL FISCAL FREEDOM:** Business rates localisation by 2020 and the prospect of the end of Revenue Support Grant means that local authorities will need to become increasingly financially self-sufficient. At this point the creation of new financial freedoms should be considered to help fund the system, shape local health economies or support the identification and pursuit of locally agreed ambitions as the Mayor of Oklahoma City was able to (see Case Study 11). This might involve a review of the two main existing local revenue streams - council tax and business rates - to assess how adaptable they are to meeting local needs, and whether new revenue raising capabilities might be considered.

## CASE STUDY 11 LOCAL GOVERNMENT DRIVING PUBLIC HEALTH IN THE US: OKLAHOMA CITY'S WAR ON OBESITY<sup>77</sup>

In 2007, Oklahoma City Mayor Mick Cornett responded to the fact that Oklahoma had one of the worst rates of obesity of American cities by challenging residents to collectively lose a million pounds of weight. To encourage this, the city underwent a civic transformation not only in the public's approach to lifestyle choices but also in the planning of the city, for example the city built parks, pavements, bike lanes and landscaped footpaths to encourage greater physical exercise amongst its residents. This was funded by a combination of \$3 billion in public

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<sup>77</sup> The Independent (6 November 2015), 'America's Most Overweight Cities: How Oklahoma is Battling Obesity', available at [www.independent.co.uk/life-style/health-and-families/features/Americas-most-overweight-cities-how-oklahoma-is-battling-obesity-a6721901.html](http://www.independent.co.uk/life-style/health-and-families/features/Americas-most-overweight-cities-how-oklahoma-is-battling-obesity-a6721901.html) [accessed January 2016].



funds, around \$15 billion in private sector funds and the increase in property taxes seen as Oklahoma became more of a desirable city and businesses and residents were attracted back. By January 2012, the city had reached its target of losing a million pounds.

## INNOVATION:

- **ROLL OUT HEALTH DEVOLUTION MORE WIDELY:** Assuming Greater Manchester's plans for health devolution and reform are a success, NHS England should be prepared to authorise a much wider rollout of health devolution to other cities and shires which can prove they have the capacity to deliver better outcomes.
- **NEW MODELS OF CARE BECOME THE NORM:** Those new models of care currently being piloted under the Vanguard programme should become the norm across the whole country, with integrated community teams of social workers, GPs, nurses and staff from the VCS becoming the norm and working closely with other areas such as housing and pharmacy.
- **PERSONAL DATA ACCOUNTABILITY TO THE INDIVIDUAL:** The government should commit that by 2020 it will explore the creation of a system which puts the citizen in charge of a single view of their own data, which they have the option of sharing with the NHS and other providers. This will unlock a new level of personalisation and prediction which can be combined with products such as wearable fitness bands to create a step change in healthcare provision.
- **REVIEW NATIONAL INSTITUTIONAL ARCHITECTURE TO ENABLE PLACE-BASED HEALTH:** The government should consider the extent to which national public sector structures need to change to support innovation. By 2020 health and local government integration will have progressed substantively, and so at this point there will be a strong case for considering how national institutional architecture in Whitehall split between the Departments of Health and Communities and Local Government might best enable local integration.

## OUTCOMES BY 2025

By 2025 our recommendations necessarily become broader and less definite. These are our aspirations for a decade in the future:

### FINANCE:

- **PAYMENT MECHANISMS INCENTIVISE PREVENTION NOT ACTIVITY:** The tariff payment structure which rewards hospitals for activity rather than prevention is completely phased out, replaced by single point locality commissioning everywhere. These use outcome-based financial models such as capitated budgets and alliance contracting as the norm.
- **PLACES, NOT INSTITUTIONS, ARE HELD TO ACCOUNT FOR OUTCOMES:** A new lighter touch ‘whole place’ national regulatory framework should have been developed by this point, which holds all services in a place to account for outcomes delivery against health and wellbeing indicators.

### INNOVATION:

- **A NEW HEALTH AND WELLBEING CONSTITUTION:** The NHS Constitution, introduced in 2012 and revised every ten years, might be extended to reflect reforms underway following the 15YFV to a new Health and Wellbeing Constitution. This would set out the rights and responsibilities of all stakeholders in the wider system of place-based health: not just clinical professionals but the range of care and support staff in the health and wellbeing system, local authorities, housing providers, community pharmacy, employers, businesses and most importantly people themselves.

## OUTCOMES BY 2030

By the 2030s, we would expect a new system for place-based health to have largely taken effect. This has embedded the reforms to this point and now has notable features:

## AT THE CENTRE:

- **NATIONAL BODIES PLAY AN ENABLING ROLE:** The role of the NHS arm's length bodies is now largely enabling, and in a largely devolved place-based system the architecture at the centre itself has reformed.
- **REQUIREMENTS FROM THE CENTRE EMBED A LONG-TERM, WHOLE PLACE APPROACH TO LOCALITIES:** The centre sets long-term budget allocations, and pursues a whole systems approach to places. A lighter touch regulatory framework holds places to account for systems outcomes rather than processes and has phased out entirely the practice of holding separate services to account for different aspects of delivery. National bodies that exist interface with localities in a way that promotes interdependent health and wellbeing systems and have a much more sophisticated dialogue with the governance structures of places.
- **ACCOUNTABILITY IS NATIONAL AND LOCAL:** The NHS remains a national service, with shared outcomes targets and governance from Westminster, but it is understood to be accountable locally as well as nationally. This has had a significant impact on driving quality and increasing transparency, in much the same way as Norway's decentralised and high quality system operates now (see Case Study 12).

## IN PLACES:

- **FUNDING INCENTIVISES PREVENTION:** Financial flows in places have changed to rebalance provision with a greater focus on out of hospital community-based services. Because hospital admissions and delayed transfers of care create cost consequences within the same budget, along the lines of that which exists in Denmark (see Case Study 13), a new community-based infrastructure is now in place and demand is more balanced.
- **STRONGER LOCAL FRAMEWORKS DRIVE QUALITY AND NARROW INEQUALITIES:** Local democratic accountability over local health and wellbeing systems means that services are more responsive to people's choices and provision is a fuller part of local democratic dialogue.

This has shifted public political discussion from one which previously focussed on postcode lotteries of service standards to a better public understanding of the postcode lottery of life expectancy and disease prevalence, and the factors that affect this. Local democratic accountability is now much more focussed on narrowing health inequalities and improving outcomes locally. The system is moving towards a 'race to the top'.

## CASE STUDY 12 NORWEGIAN HEALTHCARE SYSTEM<sup>78</sup>

Health care in Norway is decentralised and organised as a two-tier system. Primary and community health services are the responsibility of Norway's 428 municipalities, including prevention, diagnosis, treatment and rehabilitation. Specialist health care is provided by four centrally-administered regional health authorities. The government may periodically set an agenda for reform, but it is at the discretion of the regional and municipal authorities to determine how best to design and implement local solutions.

A centralised authority, the Norwegian Board of Health Supervision, is in charge of regulating all health, social and child care services. A light-touch system of regulation operates in Norway that is largely devolved to local authorities. The responsibility for supervising and monitoring both health services and health professionals, for example, lies almost entirely in the hands of County Medical Officers, who carry out around 400 quality audits of each per year. A hands-off approach to regulation, based on trust, places the burden of meeting nationally-determined standards of best practice on the provider. Rather than having a compulsory accreditation system for health care providers, for example, all providers are expected to have internal systems of quality assurance that enable them to monitor and report on adverse events and improve their services accordingly.

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<sup>78</sup> OECD (2014), *OECD Reviews of Health Care Quality: Norway*.

Norway's highly decentralised health care system is also high quality by international standards. It outperforms OECD averages on a number of health care indicators, such as mortality rates from breast cancer and ischemic heart disease, yet maintains spending as a percentage of GDP close to the OECD average.

## CASE STUDY 13 DANISH HEALTHCARE SYSTEM<sup>79</sup>

Healthcare in Denmark is administered through decentralised localities at regional and municipal levels. Regions are responsible for secondary care, and the municipalities are responsible for primary care. Following major structural reforms in 2007, municipalities became directly responsible for providing long-term elderly care, rehabilitation, supported or institutional housing for older people, public health, school health services, child dental treatment and some aspects of prevention. The municipalities are incentivised to prevent patients from requiring hospital services and provide more community-based and re-ablement services through the new financial model. GPs have a strong role to play in population health, incentivised by the fact that primary care providers co-pay for patients referred to hospitals.

Population health and prevention initiatives are working. Figures from 2009 show that Denmark has one of the lowest percentages of obesity in the OECD at 13.4 per cent, and smoking rates declined by 40 per cent over the past ten years.

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<sup>79</sup> OECD (2013), *OECD Reviews of Health Care Quality: Denmark*.

# CONCLUSION

**Critics of health devolution claimed that greater local accountability would end the ‘N’ in the NHS. This charge ignores the widespread local variations in services, expenditure and outcomes that already exist under the present system.<sup>80</sup> A national framework, entitlements and expectations of quality are integral to our health system, and even if in practice local delivery models are more responsive to needs, the unifying force of the NHS will remain as a national institution.**

The Commission’s proposals for place-based health focus on changing the meaning of the ‘S’ in the NHS: evolving from a service and to a fully integrated system. This would mean health outcomes are not done to people in a transactional manner but forged with them in a supportive system where multiple actors play a part. A National Health System would still involve building-based services and acute care in hospitals for those who fall ill, free at the point of use. But the wider place-based architecture of health and personal responsibility means that health is not seen as something that happens in a clinical setting primarily, it is something that happens in places through a wide range of partners including councils, housing providers, community pharmacies, businesses, shared spaces and people themselves.

The Commission’s approach has been designed specifically to enable local practitioners to push ahead with reforms, while at the same time seeking to design in some healthy disruption into a system that cannot continue to be shaped only by those who currently work within it. If people are to have more control over their own health and wellbeing outcomes, the system needs to shift towards enabling rather than disempowering this. We think that five factors are essential:

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<sup>80</sup> See for example, Public Health England (September 2015), *The NHS Atlas of Variation in Healthcare*.

- 1. EMBED LONG-TERM PLANNING** – we propose a Fifteen Year Forward View for place-based health which would be designed to overcome the short term operational and political pressures that prevent a focus on transformation. This would galvanise everyone within the system to work towards the same goals. It would act as a blueprint to create an agreed vision of place-based health, building on the Five Year Forward View, the Sustainability and Transformation Planning process and the emerging devolution framework. Working in a similar way to the National Infrastructure Commission, this plan would focus solely on the changes critically needed to create essential long-term transformation.
- 2. AN EXPLICIT FOCUS ON BREAKING THROUGH THE EVIDENCE PARADOX** – building credibility in the investment case for prevention is vital. Without it we will never be able to re-balance spending in a sustainable way. It is the other side of the coin to the recent call for a cross-party consensus on sustainable funding.<sup>81</sup> We champion local efforts and support a commitment from Public Health England and the Chartered Institute for Public Finance and Accountancy (CIPFA) to create a set of professional standards for creating place-based business cases for investment in prevention and early intervention. We believe this will be essential to building confidence in the process.
- 3. A RENEWED PUSH TOWARDS INTEGRATED LOCAL COMMISSIONING** – commissioning integrated services to meet the holistic needs of people has failed to gain traction. This is in part because we have dramatically underplayed the role of two functions: the role of ‘system translators’ who can cross boundaries and build trusted relationships; and the presence of ‘commitment devices’ which use financial, technological and market levers to hold systems to account on the basis of outcomes. Recognising and investing in these enabling people and functions are essential ingredients of place-based health, and we offer some perspectives on how to do this.
- 4. A ROUTE MAP TOWARDS PLACE-BASED HEALTH** – working towards 2030 we outline a route map to achieve population-level planning and commissioning, different models of devolved governance,

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<sup>81</sup> See BBC (6 January 2016), ‘Cross party review needed for health and care’, available at <http://www.bbc.co.uk/news/health-35233346> [accessed February 2016].

and a system driven by a relentless focus on citizen outcomes. This will be delivered by a step-change in the nature and quality of out-of-hospital care. The foundations of this need to be laid immediately: with much better and more consistently used insight into the grain of communities and the aspirations and assets of people. Without this, better outcomes through accountable care will be a vision built on sand.

- 5. A SYSTEMATIC APPROACH TO BUILDING READINESS FOR CHANGE** – our evidence suggests an incredible thirst for innovation and an appetite to pursue new ways of achieving better results for people and places. But the flipside is also evident: a weariness borne of ambitious initiatives that failed to stick because they lacked a credible account of how change happens on the ground. If we are to make place-based health work, then we need to invest in a transformation process that will take us to joint workforce planning, place-based outcome agreements and collaborative accountability frameworks that hold a range of organisations to account for outcomes in a place.

We hope this report furthers the debate into practical territory. Our focus has been to move beyond the institutions into places. Our intention has been to move beyond simply structural reform and concentrate on wider practice, culture and behaviour. The question for those who work in localities remains how can they lead change and work with people who are the most important part of the equation? The question for those in national bodies and government is how can this change best be enabled?

We won't have solved all the challenges or simplified the complexities that exist in one report. But we do hope to have contributed some insight into how change within the system can begin to reorient it from the ground up. This will allow the system to become more sustainable and fit for purpose in the decades going forward. The future is a place-based health and wellness system, built around people and working with them to ensure we all live happier, healthier lives. This report offers a starting point towards that vision.



# ANNEX 1: DETAILED CASE STUDIES OF THE PLACES

Outlined below are descriptions of the four areas where the Commission held evidence gathering sessions. The evidence in this report is informed by the places we visited to understand how place-based health is being developed in practice.

## BIRMINGHAM

### ‘UMBRELLA’ SEXUAL HEALTH PATHWAY

Birmingham City Council and Solihull Metropolitan Borough Council collaborated to commission the redesign of the sexual health pathway across Birmingham and Solihull. University Hospitals Birmingham NHS Foundation Trust won the bid and lead ‘Umbrella’, which is a partnership of sexual health providers across the city, including community pharmacists, GPs, charities, support organisations, Birmingham City Council, Solihull Metropolitan Borough Council and other NHS Trusts. The aim is to improve the sexual health and wellbeing of the people of Birmingham and Solihull by providing joined-up sexual health services at a number of clinics across the city on a five-year contract. Umbrella’s key objectives include a greater emphasis on integrated sexual health services that combine contraception with testing and treatment for sexually transmitted infections, health promotion and prevention, and better outcomes, such as reduction in late diagnosis of HIV & fewer unplanned pregnancies. The aim is to move focus on service provision away from being hospital-led and more towards self-care and community engagement.

### MIDLAND HEART REABLEMENT SERVICES

Midland Heart works closely with a number of CCGs and NHS Trusts to deliver a range of intermediate care and support services, based on a reablement-focussed model. These have a specific objective to

minimise length of stay in hospital, predominantly for older people and people with mental health support needs. The units in which the reablement service is offered also ensure that the transition out of hospital is as smooth as possible. Often, the units are refurbished hospital wards and are created to reflect a less clinical, more home-like environment. Midland Heart's team also deliver a programme of activities which focus on wellbeing and independence, supporting people to get ready to return to living in the community. Currently Midland Heart delivers its flagship services via three programmes: Birmingham City Hospital Ward D47 (in partnership with Sandwell and West Birmingham Hospitals NHS Trust), Beechwood (in partnership with Lancashire Care NHS Foundation Trust) and The Elms (in partnership with South Staffordshire and Shropshire Healthcare NHS Foundation Trust). Overall, the services help patients, but also acute services as they prevent crisis admissions to hospital, alleviate delayed discharge pressure, and tackle health inequalities by offering a care solution to vulnerable groups.

## POC ZERO

PoC Zero stands for Point of Contact 0. It is an approach to address the wider determinants of health and wellbeing in Birmingham, recognising that health needs occur before a person gets ill and has to visit their first point of contact, a healthcare professional. It is a partnership between GPs, acute hospitals, community health, pharmacies, housing, social care workers, charities, volunteers, community groups, businesses and academics. All partners work to collaborate around real people in their communities to develop and connect local assets to evidence-based outcomes. The methodologies which help them to do this include mapping existing community assets, analysing the different groups within the community, creating space for them to innovate and connecting local assets together. The architects of PoCZero needed to understand population areas, and did so by building a depersonalised data set for each population including the prevalence of specific health conditions and social media trends in order to perform an area sentiment analysis. This helped them to convene appropriate starting points for conversations with the communities in target areas, thereby tailoring the services of Healthy Villages towards people's real-life needs.

The partnership has developed its own governance structure whereby all key partners are represented to manage risk, be accountable and contribute to the approach.

## SUFFOLK

### **‘CONNECT’ EARLY ADOPTER PILOTS**

There are two early adopter pilots in Suffolk covering two geographical areas: Connect Sudbury and Connect East Ipswich. Connect joins up services within a place around the person requiring need, moving towards a more integrated system of health and care services. It is a partnership between GPs, nurses, hospital doctors, social care professionals, councillors, blue light services and local charities. The main aims are outcomes around healthier, happier people, empowerment, personal responsibility and reduced social isolation. There are four main elements to the pilot sites: prevention, integrated care coordination, urgent care response and treatment, and returning to independence.

There is a joint leadership approach between Suffolk County Council and the CCG. Integrated Neighbourhood Teams consist of various health and social care professionals who join-up around the individuals requiring help through multi-agency team meetings to discuss common cases, and working towards the same outcomes. Neighbourhood Networks are made up of families, friends, colleagues, community groups, charities, GPs, pharmacists, and all the other people and organisations a person will interact with regularly. Social connections are well-acknowledged as playing a key role in a person’s wellbeing, and therefore the Neighbourhood Networks tap into the social capital which already exists to build community resilience.

### **WEST SUFFOLK INTEGRATED CARE ORGANISATION**

The West Suffolk health and care system (including the CCG and the county council) has initiated steps towards an Integrated Care Organisation (ICO), to integrate health and social care services across

the locality. A Shadow ICO Board has been created to oversee development plans as the ICO is phased in over 2016/17. A capitated payment system is being developed with the objective of ensuring that all partners in the ICO are working towards the same aims and outcomes.

## SUNDERLAND

### INTELLIGENCE SERVICE

Sunderland City Council are developing behavioural insights into their population through extensive data collection on an individual and family level. The council have commissioned Palantir, a Silicon Valley technology company, to create a database with a 360 degree view of the interactions that individuals have with the system. At present this includes data from social care, children's services, the police, youth offending teams, the biggest registered social landlord in the city and schools. The missing piece of the puzzle is accessing health data, from both hospitals and GPs; the Intelligence Service is in conversations to get as many advocates as possible from across the health system, as the work will support the priority around the integration agenda. The holistic, big picture view of a person's interaction with the system will be used to make effective decisions, understand predictions and potential triggers, alongside more effectively tailoring service provision and making the best use of resources.

### COMMUNITY CONNECTOR PILOTS

There are five Community Connector pilots in Sunderland, working across the well-established 'Area Arrangements' of the city. The Community Connector model is an initiative by Sunderland City Council to work in partnership with the local voluntary and community sector (VCS). Each area is allocated £20,000 from the CCG, which is matched by the council. The council's role has moved from being the deliverer of services, to the enabler of services through pump-priming, for example providing office space for the Community Connectors to give a physical presence and open up other doors for funding. Community Connectors are members of the VCS area

network with a job description to share information, refer within and between different organisations, and signpost people on if and when necessary, to provide people with a more streamlined, accessible way in to receiving the services they need in a place.

## **ALL TOGETHER BETTER SUNDERLAND**

All Together Sunderland is a vanguard site initiative planned by Sunderland City Council and NHS Sunderland CCG, and designed to help empower people and communities to help themselves achieve a more rewarding and fulfilling life. The programme has three elements – ‘recovery at home’, ‘community integrated teams’, and ‘enhanced primary care’ – and themes covered include money management, families, wellbeing and an accessible city. Partners include Age UK Sunderland, pharmacies, hospital trusts and local GPs. The vision for the programme is to help re-shape out of hospital care, enable more self-care and focus on a more proactive, patient-centred and preventative approach.

## **SUTTON**

### **SUTTON UPLIFT**

Sutton Uplift is an integrated Primary Care Mental Health service accessible to anyone living in the borough of Sutton or registered with a Sutton GP over 18 years old which launched on 1st July 2015. The service has four key elements: The Referral Centre, Recovery Team, IAPT (Improving Access to Psychological Therapies) and Wellbeing. It is a partnership between the NHS, GPs, CCG, mental health services and local voluntary sector organisations, as a model of single point of access in health and social care to assess all needs in one go. Its main aim is to bring support for mental health problems around the individual with a focus on building resilience and with help closer to home. Through building people’s social capital and resilience, it is planned to reduce demand on GP and health services, for example through self-management and fewer appointments and less clinical time. Underpinning this is the Wellbeing Arena as a central resource base and drop-in centre which means people don't have to be

'known' in the system to access the service. Wellbeing Navigators are employed by Imagine, the charity leading the Wellbeing Arena, and they help to empower people and build resilience through hand-holding, signposting or providing tailored support.

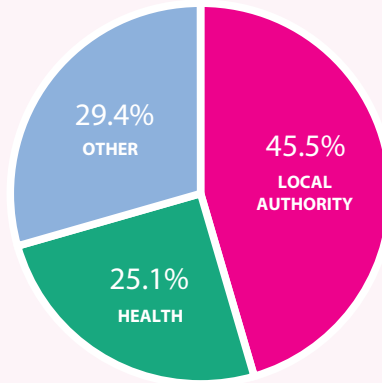
## COMMUNITY WELLBEING PROGRAMME

London Borough of Sutton are implementing a Community Wellbeing programme as part of a new 'social contract' between citizens and the state, to encourage people and communities to stay healthier for longer. The programme is aiming at reducing social isolation and will include early intervention and prevention initiatives, to reduce demand on reactive public services, and to support the council's corporate plan – the Sutton Strategy. Building community resilience and social capital are two key components of achieving greater community wellbeing. The programme is delivered at three levels: borough wide; local committee or ward-based; and at the street or community level. A key part of the programme is tapping into community assets, such as volunteering and the development of a Sutton time bank. It is a recognition that all statutory and non-statutory services in a place have a vital part to play in developing community wellbeing.

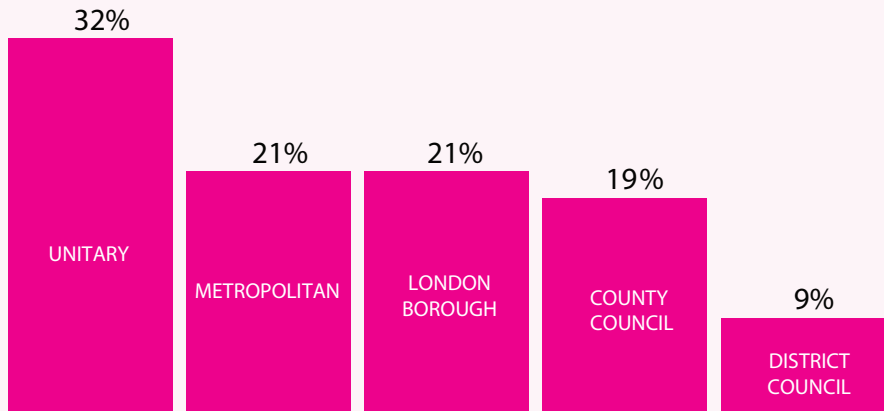
## ANNEX 2: ABOUT THE SURVEY

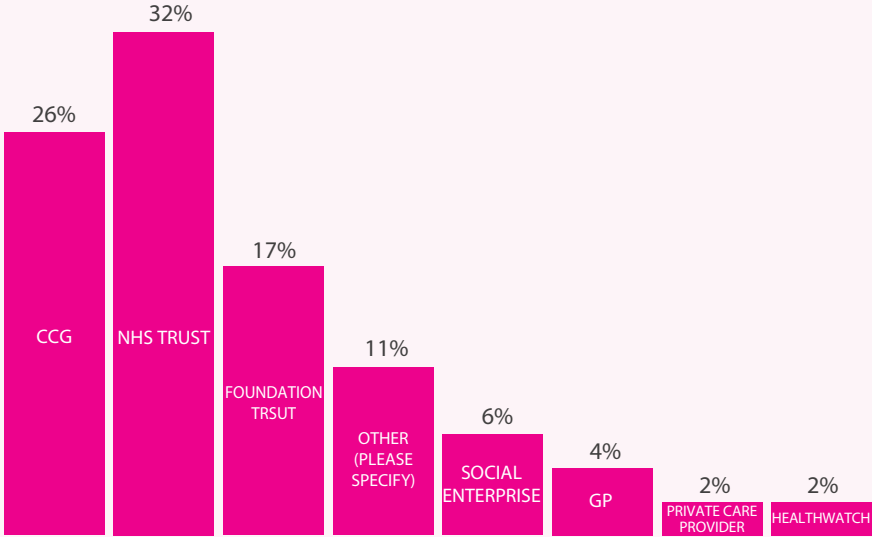
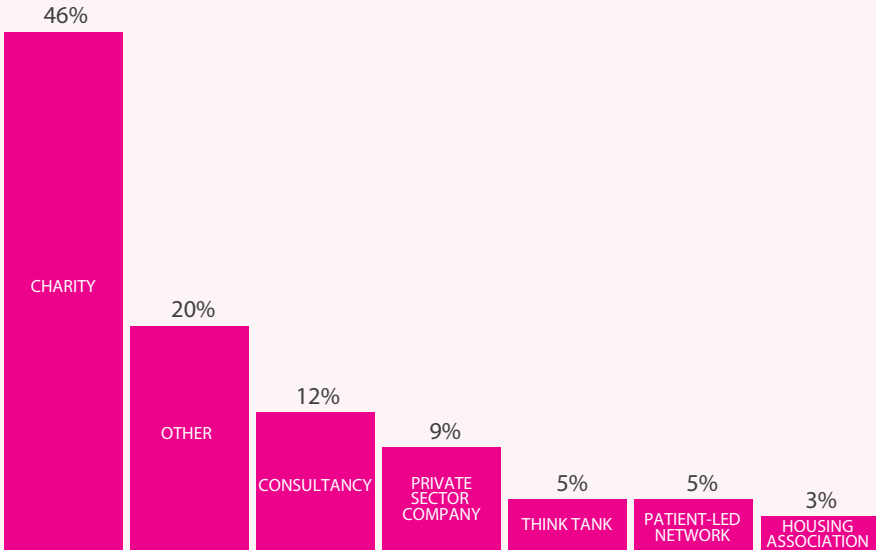
The survey was sent out to senior officers and heads of services within local authority departments across adult social care and public health, to health sector professionals from CCGs and NHS trusts, and members of the voluntary and community sector. The survey was in field for four weeks in July 2015. In total there were 231 respondents. The following charts demonstrate the type of organisations respondents worked for.

**FIGURE 17** WHAT TYPE OF ORGANISATION DO YOU WORK FOR?



**FIGURE 18** LOCAL AUTHORITY: WHAT TYPE OF ORGANISATION DO YOU WORK FOR?



**FIGURE 19** HEALTH: WHAT TYPE OF ORGANISATION DO YOU WORK FOR?**FIGURE 20** OTHER: WHAT TYPE OF ORGANISATION DO YOU WORK FOR?



# ABBVIE

**The Commission is supported by a funding grant from AbbVie, which was founded in January 2013 as a global biopharmaceutical company with the focus and capabilities to address some of the world's greatest health challenges.**

AbbVie has the stability, resources, expertise, and passion to discover, develop, and bring to market groundbreaking science to solve the biggest health problems that face the world today and tomorrow. They are comprised of 28,000 people focused on developing new and specialised medicines products and new ways to help people manage some of the most serious health conditions. The team is made up of scientists, researchers, regulatory experts, manufacturing and commercial specialists. AbbVie unites the best of pharma and the boldness of biotech, to innovate end-to-end approaches that make a real difference in people's lives.

For more information, visit [www.abbvie.co.uk](http://www.abbvie.co.uk)

# BRITISH RED CROSS

**The British Red Cross helps people in crisis, wherever and wherever they are.**

They are part of a global voluntary network, responding to conflicts, natural disasters and individual emergencies. Red Cross helps vulnerable people in the UK and abroad prepare for, withstand and recover from emergencies in their own communities.

Red Cross have provided health and social care services within the UK for more than a century. They provide support at home, transport and mobility aids to help people when they face a crisis in their daily lives.

Red Cross believes everyone should get the support they need to live independently at home.

For more information, please visit [www.redcross.org.uk](http://www.redcross.org.uk)

Supported by:



# CITY HEALTH CARE PARTNERSHIP CIC

**City Health Care Partnership CIC is a co-owned, independent health services provider separate to the commissioning organization NHS Hull. It officially formed in June 2010, and as of June 2016 it will have been an independent provider of NHS and Local Authority commissioned services for six years.**

Having spun out of NHS Hull with an income of £48 million and 1200 employees, it now has an income of over £70 million and employs 1500. It has also succeeded in rewinning its original contracts for a further seven years, diversified its business to the North West, and established innovative businesses to help it manage its income and expenditure effectively (City Ventures Ltd and Tangerine Discretionary PCC Ltd). It maintains excellent patient satisfaction with 98 per cent of service users reporting being very satisfied with their experience, standard and support received at the organisation.

For more information, visit [www.chcpcic.org.uk](http://www.chcpcic.org.uk)

**City Health Care Partnership CIC**

a co-owned business

# MIDLAND HEART

Midland Heart is a leading UK housing, care and support business, providing high quality housing and supported housing. Founded in 1925 their vision is to transform lives and communities through housing, care and opportunity. Midland Heart works in some of the most disadvantaged neighbourhoods to build new homes and strong communities, along with neighbourhood services for 70,000 customers, across 55 local authority areas. In care, they support 7,000 customers that aim to help an individual to live an independent and happy life.

Midland Heart innovates to bring health into the home through a range of service models that blend housing, care and public health initiatives. These include preventative services that manage long-term conditions, delaying the escalation of social care needs and services that support people home after a stay in hospital – all to support an individual to live with dignity and independence in their own home.

For more information, visit [www.midlandheart.org.uk](http://www.midlandheart.org.uk)

# WALGREENS BOOTS ALLIANCE

Walgreens Boots Alliance is the first global pharmacy-led, health and wellbeing enterprise. The company was created through the combination of Walgreens and Alliance Boots in December 2014, bringing together two leading companies with iconic brands, complementary geographic footprints, shared values and a heritage of trusted health care services through pharmaceutical wholesaling and community pharmacy care, dating back more than 100 years.

The company is the largest retail pharmacy, health and daily living destination in the USA and Europe and includes one of the largest global pharmaceutical wholesale and distribution networks. In addition, Walgreens Boots Alliance is one of the world's largest purchasers of prescription drugs and many other health and wellbeing products.

Its portfolio of retail and business brands includes Walgreens, Duane Reade, Boots and Alliance Healthcare, as well as increasingly global health and beauty product brands, such as No7, Botanics, Liz Earle and Soap & Glory.

For more information, visit [www.walgreensbootsalliance.com](http://www.walgreensbootsalliance.com)



Walgreens Boots Alliance





**Our health and care services are not sustainable: demographic changes and lifestyle diseases are creating growing demand pressures and funding has failed to keep pace. There is widespread consensus that we need to shift the balance of resources away from treatment and towards prevention. Despite waves of reform and good intent, this systemic shift has so far proved elusive in practice.**

NLGN and Collaborate established the Place-Based Health Commission, chaired by Lord Victor Adebowale, to address these challenges. This final report moves the debate into practical territory by focussing on actions rather than structures, and the wider resources of places rather than the organisational boundaries of institutions. It sets out a route map for making a long-term shift towards a system that supports people's health and wellbeing and is fit for purpose for the future.

***Kindly supported by:***



**City Health Care Partnership CIC**

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MS3 LPBW Logo**