

# Joint working to deliver better care

London Health & Care Integration Collaborative,  
in partnership with SCIE and PPL  
5 October 2015: Event report



# Introduction

On 5 October 2015, the London Health and Care Integration Collaborative, the Social Care Institute for Excellence (SCIE) and PPL came together to deliver an event for London on the theme of joint working to deliver better care. The event was attended by around 70 people from across London with an interest in or involved in delivering integrated care.

The aims of the event were to enable participants to:

- Learn about practical steps they can take to develop joint working and ensure it works effectively, e.g. developing an effective communications and engagement strategy, leading co-ordinated, co-located teams, and co-producing change with people who use services
- Hear from experts on the integration of health, social care and wider services
- Share learning and practice about what works from across London and network with others involved in leading joint working for integrated care.

Taking the form of a plenary session, followed by in depth breakout sessions, the event drew extensively on the learning from comprehensive work by SCIE and PPL on integration, including two How To Guides produced on leadership and joint working, as well as from examples from within London.

The organisers are grateful to all the speakers and workshop facilitators and to everyone who took the time to attend.

This short report provides a summary of the discussion. Copies of the presentations are also available on [London Councils website \[link\]](#)

**“Leaders are there to make good things happen and to stop bad things from happening”**

[service user quoted by one of the speakers]



# Key messages

- **Prevention, early intervention and integrated care are all linked and it is not helpful to view them as independent of each other.**
- **It is important that leaders are able to look beyond their own organisation to the needs of the system overall.**
- **Having the right conversations about risk sharing and the ability to take risks is extremely important.**
- **We need to see communities and people as assets with contributions to make and to move away from a focus on meeting needs to a focus on realising potential.**
- **People need to know that they have the power to shape their own care.**
- **Getting staff buy in and valuing staff contributions and ideas is critical.**



# Plenary session

## Welcome and lessons from London

### Martin Smith, Chief Executive, London Borough of Ealing and Chair, London Health and Care Integration Collaborative

Martin Smith welcomed everyone to the event and explained that in his view it was a critical role of the London Collaborative to bring practitioners together from across London to find real solutions to real problems. He noted that London had performed somewhat better than the national average in relation to BCF plan approval which could be partly down to initiatives like the London Collaborative that provide support for people working on these issues on the ground. He explained that London was only in the position it was in relation to being able to put together a case for greater devolution because of the strength of relationships across health and social care here.

Martin also made the following points:

- There seems to be much greater scope for local variation and this seems to be more tolerated and encouraged, over national roll outs alone, than it was at one time.
- There is evidence that integrated health and care improves outcomes but no evidence as yet that it saves money, however this evidence will not become available unless integration schemes continue to be tried, tested and evaluated.
- Prevention, early intervention and integration are linked and we can't do one without the others.
- There is still work to be done to address the information governance and workforce barriers to integration. Accountability regimes, financial management and regulations are fundamentally different across NHS and local government and so there is still a need to work round these to get things done.

## What is good integrated care?

### The user experience – Dr Ossie Stuart, SCIE Associate and Equality and Diversity Consultant

Ossie Stuart explained that he had been talking to a lot of disabled people around London about their experiences of using health and care services and so his talk today was based on the real things that people using services think about.

He focused on four key challenges that need to be overcome before we can integrate care:

- **Trust** – It is important to win the trust of people who are sceptical about whether integrated care will work for them.
- **Communication** – We need people to understand that they can shape their own care.
- **Power** – Are we ready to give up control to the person using health or care services? Integrated care requires a power shift.
- **Realism** – Can it really work? Will it work for people with complex needs or mental health needs?

## Building services around the needs of people who use them: the role of good leadership - Sarah Pickup, Deputy Chief Executive, LGA

Sarah Pickup set out her thoughts that the role of leaders is to:

- Do the right thing
- Have an end to end view
- Build relationships
- Understand different drivers, and
- Enable and unblock (e.g. conflicting priorities preventing people from working together).

She stated that: “We need to keep going back to what we are trying to achieve – asking what people’s needs are, what they want, and who are the people we are talking about?”

On prevention, she noted that, prevention stops us from spending money on the wrong things later. It includes providing information, advice, signposting at all stages where care is provided and also targeted preventative interventions (e.g. to prevent falls and incontinence) and short term interventions (acute care, medication, enablement, therapy and rehabilitation).

Other important areas to focus on include:

- Personalising care and support.
- Frontline approaches and attitude, e.g. positive deviance.
- Organisational approaches and attitudes.
- Cross organisational and cross-profession approaches and attitudes e.g health and wellbeing boards, providers and commissioners.
- Developing a culture of clarity, consistency, connectivity and collaboration, encouragement, support, engagement and persistence.



**“We aim to deliver better care, but it is even better if that care is not needed in the first place ”**

## Joint working: key themes and lessons from around the country

### Tony Hunter, Chief Executive, SCIE

Tony Hunter shared some of the work that SCIE has done to support integrated care and the learning from this. Key points included:

- Grabbing at solutions is not always the right thing to do and gives a false sense of making progress.
- We need to be careful about pandering to the need for certainty and the desire to immediately intervene. Sometimes we need to step back and roll with ambiguity.
- We need to share and absorb risk as a complete system so that we can share learning from our mistakes.
- Our perceptions are based on where we sit in the system. We need to see it from other perspectives and not be obsessed by our own organisations – and not by what we're actually here for. We need to model this by challenging ourselves.
- We need to see communities and people as assets with contributions to make, to move our focus from meeting needs to realising potential.



**“There is a risk that we are obsessed by our own organisation – and not by what we are trying to achieve”**

## Q & A and discussion

The chair, Claire Kennedy summarised the key points from the session as:

- Focus on outcomes versus processes.
- Develop collaborative leadership and trust across organisations and roles.
- Accept 'positive deviance' and be willing to go against perceived wisdom.



### Questions:

#### **How do we facilitate a move from the 'them and us' mentality between health, social care and people who use services?**

Ossie Stuart responded saying local authority staff are fearful about their jobs, and fearful of failure. He continued, "I need to understand their world view – they are worried about making too many promises, and I get that. The challenge is how to empower your frontline staff to do their job well."

A dietician from a hospital outlined the challenges they face when it takes five to six days to get someone out to community settings with support in place.

Sandy Marks, service user, highlighted the forthcoming NICE guide on transitions between hospital and community settings which includes a recommendation that the system needs to start planning once coming in to hospital.

#### **How do localism and centralism targets fit together?**

Sarah Pickup responded by questioning whether devolution would lead to NHS England letting go of centralised power. It is still unclear what will happen, and perhaps accountabilities need to change. Kevin Minier, a carer, raised the point that without carers, the system would collapse, and called for solutions to be genuinely co-produced with people who use services, carers, providers and commissioners. For example, why do people have to wait six to eight weeks for rehabilitation, when it is too late? We need post-acute support, not just preventative care. Key point is that we are not using resources to best effect. Why can we not do zero-based commissioning and agree what hospitals, social care and other services are going to provide?

Sarah Pickup highlighted that the role of leaders is to spot the small things that can make a difference. Sometimes it is about going slowly, not reinventing the wheel – but stealing with pride from others.

Another delegate raised the point that staff cannot afford to live in the area in which they work. We need to support and understand what is available in the area for our staff.

# Breakout sessions

Each breakout session considered critical challenges to effective integration, and key actions that may help to address these. The following is a summary of the main points from each session.

## Breakout 1: Leading effective implementation: lessons learned

**Facilitated by: Lisa Larsen, Chief Operating Officer, PPL Consulting and Deborah Jenkins, Associate Director, PPL Consulting**

The group identified the following critical challenges to effective implementation:

### i. **Competing priorities and structures of social care and health**

- Health and social care often have competing priorities which can have an impact on implementation. These priorities can sometimes hinder the way that service users are kept engaged in the process.
- The disaggregation of health and social care funding and structures can sometimes be a challenge to effective implementation.

A key action to address this challenge should be to ensure that there is a holistic approach in dealing with people regardless of what services they are receiving, but this is particularly essential where people require both health and social care services.

### ii. **Consistent terminology and support systems**

- There is a need for greater consistency in terminology between health and social care including having a shared understanding of what integration means for all stakeholders. Currently different words have a different meaning for different people depending on which part of the system they operate in.

To address this challenge there needs to be a common understanding in terminology to ensure that systems are addressing the same issues and have similar expectations.

### iii. **Leap of faith and better sharing of risks**

- Organisations need to share risks (and benefits), they need to take a leap of faith and commit actual funding to make it work so that implementation plans can more easily be moved from concept to reality.
- There are several concerns and issues that organisations have that limit their commitment of resources and implementation of faith that would need to be addressed so that organisation can take that leap of faith and commit themselves – these would need to be addressed.

### iv. **Progressing beyond the concept to reality**

- Progress can sometimes be hampered because the focus is too narrow. Sometimes even when there is agreement in principle it can still be quite difficult to implement in practice - for example the reality of day to day pressures can limit integration and funding pressures can affect ambition and the appetite to take on more risks.
- Managing expectations for scale and pace can also be problematic.

Key actions to address these problems include:

- There is a need to encourage people to think beyond just their organisation so that there can be a better understanding of the bigger picture amongst staff across both health and social care.
- Desired outcomes need to be the focus of the work and therefore integration should not be a driver. Integration therefore should not be the driver.

#### **v. Funding models and incentives**

- Funding and financial pressures on the system continues to be challenging - these funding pressures were compounded by the fact that the Better Care Fund (BCF) funding was not new money.
- The financial penalties under the BCF have been found to hamper effective implementation in some areas and could limit integration in some areas.
- It is also a problem that even where there are examples where pilots/demonstrators are shown to be working effectively, there is no follow-on funding provided to enable wider implementation.
- The funding of health and social care is fundamentally different and has implications for effective implementation – i.e. access to NHS services is free while access to social care services is assessment based.

To help overcome these challenges the following actions were identified as possible actions that could be taken by local areas:

- Focus on what is working.
- Change financial investment structures to make the more efficient.
- Align targets and incentives to be at the interface to encourage real integration.
- Ring-fence funding to address particular problems.
- Acknowledge that sometimes we need to double run to transition to integrated model – cost implications.

#### **vi. Workforce challenges**

- The way health and care is provided is changing and people's expectations are also changing and therefore the needs of the workforce are changing.
- There is weariness amongst the staff across both health and social care organisations and concerns regarding the top-down approach taken in most organisations.
- For operational staff there are risks with uncertainty of organisation responsibility and therefore do not feel empowered to make the decisions that are needed.

Overcoming these challenges would require the following:

- A shift is needed in the workforce to become more 'outcome focused' for the benefit of the individual. There is a need to take away the discussion of who's responsible for some activities as this can sometimes be a hindrance and delay the desired outcome.
- A joint understanding of what is required from the workforce to deliver care is required and should be based on organisational unit. Skills should be focused on where they best needed.

## vii. Governance and leadership, building trust

- It was identified that sometimes there were poor relationships between partners and that there was a need for strong leadership to help strengthen relationships and overcome these challenges. Examples were given of where organisations agree and promise to deliver certain things but then they don't follow through in practice and this results in poor relationships which have an impact on delivery.
- It was acknowledged that local relationships had developed at a variable pace across areas and therefore local relationships in different places had achieved different levels of maturity - in some areas there are strong working relationships.

Some of the actions that were identified for overcoming these challenges are:

- Governance structures need to represent all key stakeholders and decision makers.
- The Health and Well Being Board should put up new ideas and solutions and ensure work across the whole community

## Breakout session 2: Leading and managing co-ordinated delivery teams including statutory, voluntary and private sector

*Facilitated by Patrick Hall, Practice Manager, SCIE and Joe Nguyen, Manager, PPL*

The group identified the following challenges to leading and managing coordinated delivery teams including statutory, voluntary and private sector organisation and also proposed some actions needed to overcome these challenges.

### i. A risk averse culture

- The whole system has a risk averse culture. This culture means that teams are hesitant to take risks and this has an impact on the management and coordination of multi-sector delivery teams.
- The system fails to give people /the workforce the freedom to experiment within a hierarchical structure, without the risk of punishment.

The group then suggested the following actions were key if these challenges were to be addressed.

- Culture change in the organisations and the workforce is required, however it is unclear whether there is the appetite for culture change?
- There needs to be endorsement and support from senior management – it is important that senior management is present and supportive of initiatives, otherwise staff may see the lack of involvement by senior management as a the message that they don't care.
- Focus on small wins, e.g. the benefit to a patient; identify this through listening to the patient's story.

### ii. Unclear messaging across the system

The group discussed the issue of messaging in the system and considered this to be a challenge. Some of the challenges regarding messaging are outlined below:

- Messaging in the system can sometimes be unclear for both the workforce and the service users because assumptions are made that senior managers will cascade messages to their staff while there appears to be an assumption that staff who are not senior managers are perceived as being without value.

The main action identified for resolving this was the need for a clear communication which would need to be clear as all levels of the workforce. There must also be a clear communications strategy on how information will also cascaded down to the end users.

### iii. **Lack of interoperability of IT systems between health and social care**

- Lack of interoperability of IT and information sharing was considered to be a challenge in managing multi-sector teams as sharing medical history of patients is difficult, meaning that patients or their carers need to explain the patients' journey each time they are in contact with the health or care system.

The need to ensure that GPs, hospitals and social care organisations develop and use common interoperable systems was considered to be an important action that is required.

### iv. **Support/care or accommodation models are not suited to the patient**

- It was discussed that residential care is often mistakenly considered 'risk free' but it is actually creating a dependency that moves the pressure from one part of the system to another, rather than solving the problem.

As a possible solution it was discussed that there was need to seek out and take up more opportunities for re-ablement, e.g. in nursing and care, and funded community assets. Fit the patient to the package.

### v. **Empowerment/barrier towards personalisation**

- People/patients are seen as problems, whilst professionals are seen as the problem solvers

The group discussed that people themselves are part of the solution and need to be proactively empowered by staff. For example staff must enable patients to do self-assessments where possible.

### vi. **Challenges of MDT or inter-organisational working**

The challenges of multi-disciplinary teams and organisational working were identified as a challenge for management and coordination of delivery teams. In particular the following issues were raised:

- Governance and information governance: e.g. difficult to get charities honorary contracts.
- Setting up nhs.net email accounts.
- Maintaining integrity around patient-identifiable data.
- Different organisations' 'agendas and priorities'.
- Building trust between organisations.
- Capacity of the voluntary sector.
- Contribution of the private sector is undervalued.
- We don't collate any data from the private sector even though they may be delivering a service to patients on a daily basis.

The following solutions were put forward for these challenges:

- IG can become a barrier when security is prioritised over functionality – functionality is therefore very important if it's to be effective.
- Communication – we need to tell patients about the benefits of sharing their information and have less scaremongering.
- Patients should be encouraged to actively consent to sharing their most recent information/ medical history.
- Include voluntary and private sector staff, patient and carers in MDT meetings.
- There needs to be better coordination of meetings while being mindful of time burden on all present (frequency and duration).
- Build relationships over time.
- Better engagement and co-location of teams.
- Careplace (West London) is a good example [link]
- Planning and organising is paramount, through good leadership and coordinators
- Social care providers are a key part of the system – we need to ensure that colleges and independent care providers are fit for purpose.
- The voluntary sector and its expertise should also be drawn on more.
- The private sector should also be included in strategic discussions, communication and information sharing as they are currently excluded even more than the voluntary sector is.

vii. **Embedding new initiatives into business as usual (from projects)**

- It was discussed that embedding new initiatives as part of business as usual can sometimes be a challenge because people often cling to old ways of doing things and this can result in inconsistencies and at times it can lead to confusion.

A solution for this was that it was important that citizens and all staff were aware of the initiatives and the impact that they have. There also needs to be a review to get a better understanding of why a particular initiative may have failed e.g. poor implementation of the initiative or maybe it was underused.

viii. **Under supply of the workforce**

- Recruitment was identified as a challenge and some of the roles are no longer considered attractive and are underpaid. It is becoming increasingly difficult to train enough people.
- In London retention is an issue and the poor pay and link to the affordability of accommodation is increasingly a problem the low pay could be acting as a deterrent to people from joining the sector.

The following potential actions for addressing these challenges were discussed:

- Definitions/roles of professionals need to be slightly 'blurred' or overlapping so that they are made more attractive and it is easier for people to move between roles.
- The solution needs to be collective and innovative; not just solving the problem in one area (e.g. through bonuses).
- Systems and operations need to be better aligned.
- Avoid cyclical arguments in commissioning and provision – commissioned services need to meet the organisation's outcomes.
- Avoid the silo-mentality there needs to be more cross overs between systems.

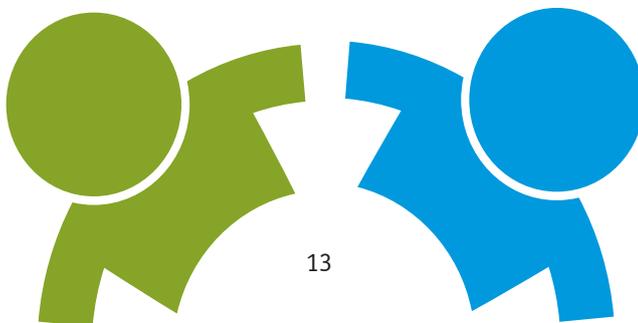
#### ix. **Workforce development**

The following challenges were raised with regards to workforce development:

- Systems need to invest in training.
- Skills and knowledge need to be right for the role – pre-registration training needs to be right to start with.
- No integrated/pooled funding for workforce development (only at local level).

The proposed solutions for addressing these challenges are outlined below:

- Outcome based, multidisciplinary training is needed.
- Culture change – training needs to include an understanding of the system and how people work not just what they do by job title.
- Quality standards for training need to be given.
- Care certificates as part of induction.
- Integrated apprenticeships.
- Reflective learning – importance of supervision.
- Train the trainer approach.
- Create a learning culture and the application of training: in-role training, learning and development.
- Need consistent work plans to set out how people are expected to work.



## **Break out Session 3: Communications and engagement**

**Facilitated by Simon Morioka, Managing Director, PPL and Iris Steen, Head of Communications, SCIE**

### **Integration: what does it mean?**

- There is a lack of shared understanding of the concept 'integration'.
- Key issue is to communicate goals and tangible outcomes so people can relate to it.
- People prefer coordinated care and clear pathways over 'integration' – the service should just work.
- "We all use bricks, mortar, windows and doors, but the final buildings are completely different".

### **Integration: what does it embody?**

- The person is centre stage at all times.
- Integration cannot be described in one sentence – it needs to be viewed in small sections and include local needs that are timely.
- Integration is about equality.
- For the person who uses services, it means being able to remain in your preferred environment; surrounded and supported by compassionate professionals with the right skills to meet your needs.
- The system should be flexible to meet the changing and multiple needs from the patient.

### **How to shape integrated care**

- Share information on the availability of care and services, i.e. who offers a service, who can refer quickly?
- Provide access to support that addresses the person's current needs, and prevents progression and emergencies from happening.
- Co-ordinate professionals and services to prevent need for unnecessary referrals.
- Provide multi –disciplinary care which is necessary to implement a holistic approach.
- Work within a regulatory framework that enables professionals to exercise some flexibility on behalf of the whole system.
- Ensure the person is at centre: so they receive the care they wished for, not provider-induced care.
- Care integration is not just about a particular model. It covers continuous efforts to improve different elements of the care service, and it is about equality between professionals and patients/users.

### **Engaging with staff**

- Get staff buy-in first, followed by workshops with people who use services and who may raise critical questions, followed by piloting with the aim of learning lessons to enable the final model to be shaped afterwards.
- Use patient stories instead of statistics to illustrate issues and create positive attitude to change from staff – e.g. Through 'walk in your shoes' workshops.
- Engage with people with the right attitude: realism and enthusiasm is key to success.
- Hold training to foster shared understanding. E.g. enabling GPs to share their experiences with other professionals.
- Enable people to voice views and opinions by fostering an environment where transparency and honesty are key, to enable open discussions to be held and staff at senior levels function as role models.

- Ensure that people's contribution leads to improvement - staff contributions should be valued.
- As professional training and educating younger colleagues it is important to ensure transparency and engagement is part of good practice. This will ensure that fostering a culture of transparency and dialogue, is part of business as usual.
- Engagement is not a one-off item – it's a continuous dialogue.
- Engage with the voluntary sector:
  - The Centre for the Voluntary Sector (CVS) is often engaged with – but they don't represent all voluntary and community organisations.
  - Establish a forum where all are represented.
  - Reach out to the voluntary sector as well as engaging in formal settings.

### **Engaging with patients**

- The benefits of implementing co-production at all stages:
  - It leads to realistic expectations.
  - Patients/users are pragmatic about priorities.
  - They remind you of why you are there.
  - They keep you to your commitments.
- Essentials:
  - Engagement is not free, it should be budgeted for (which is often overlooked).
  - Involve people at the right time (i.e. not at the end when it is too late to change things).
  - People must be aware they are representing the community not themselves.
  - Ensure accessibility to demonstrate true engagement via physical access, communication and ease of understanding (language and acronyms), photos etc.
- Questions:
  - Try to manage patient and users expectations by fostering trust through transparency.
  - Co-production should include all parties to get insights into each other's opportunities and constraints.
- It is important to ensure that patients/users are engaged with in their own community rather than expecting them to come to the organisation.
- Avoid only consulting with members of user groups, and ensure that the reach is extended to others in the community.

### **Communication**

- Use staff on the front line to disseminate information up and down as this encourages staff not to be afraid to communicate.
- There are some potential barriers to be aware of including, the differences between social care and health care and the differences in hierarchy.
- It is important to respect each other and each other's opinions
- Be authentic and honest.

## Breakout session 4: Co –producing new models of care with people who use services and carers

**Facilitated by Tony Hunter, Chief Executive, SCIE and Ossie Stuart, SCIE Associate and freelance consultant**

### Co-production – the process

- About power.
- When to involve someone in the process.
- A big challenge, needs planning and is not easy.
- About devolving power to people outside of your own organisation.
- People giving time freely versus the employed, so what is the offer and reward for people helping?
- Reflection of their efforts they are putting is needed [Example: LB Islington pay the London Living Wage].
- Important that co-producing new models of care needs to be with people who use services and carers.

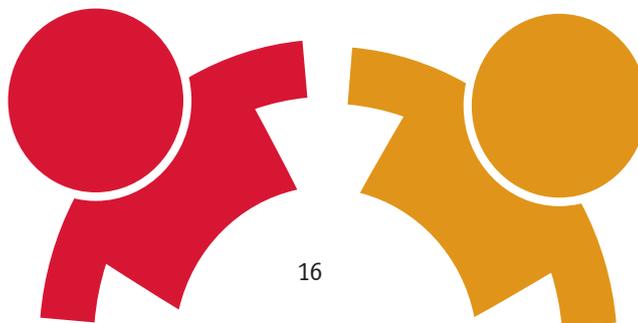
### What's working out there already?

- Camden Active Living Group has been established, developing new ways of communication process – patient/user engagement in the development of their services. Project started 6 months ago.
- Redbridge – Day Opportunity Services, redesigning of services and re-assessment of user's needs which has resulted in re-training. Moving to a system which people want. Positive Service Users experience of engagement.
- LB Islington have run non-taster sessions as a communication source.

### Challenges

- Austerity.
- Politicians and decisions/budget consultations – a whole challenging choreography.
- The above two points could be an excuse not to go ahead with co-production.

**“ We are the ‘they’ - everybody can contribute! ”**



### **Other Considerations:**

- If you give users responsibility for their care you need to give them power – sharing responsibility.
- Bringing user/carer groups together to learn from other people's experience.
- Accessibility and messages need to be clear e.g. with regards to PAs and DPs.
- Communication is vital however, local authorities not too good at this.
- There is a need for local government also to have access to information and to also take responsibility of what is on offer.
- Enabling people to try out things to build confidence.
- Personalisation is 'personal' and relevant to that individual.
- Cultural change is huge – is a key point.
- Language is always an issue.
- Tokenism – there needs to be challenge back.

### **Ossie's Summary:**

- Co-production is real and practical – empowered.
- Resourced properly – respected and time recognised and not necessary rewards meaning money.
- Patronising, symbolic or genuine conversation.
- Co-production more important due to cuts.
- Ethical issues – decision made for someone else's life.
- Move towards change and better services.

## **Closing Plenary Session**

A representative from each group was invited to feedback key points from their break out. The event chair, Claire Kennedy, summarised the main points from the afternoon's discussion and thanked everyone for taking the time to attend.

# Appendix One: Programme

## Joint working to deliver better care

Monday 5 October 2015

12.00 – 17.00

Venue: London Councils, 59½ Southwark St, London SE1 0AL

12.00 – 12.30	Registration and Lunch	
12.30 – 12.40	Introduction from lead facilitator	SCIE or PPL Director
12.40 – 13.00	What is good integrated care? The user experience	Ossie Stewart SCIE Co-production Network
13.00 – 13.30	Building services around the needs of people who use them: the role of good leadership	Sarah Pickup Deputy Chief Executive, LGA
13.30 – 14.00	Joint working – How to <ul style="list-style-type: none"> <li>• Lessons from How to Guide</li> <li>• Lessons from London</li> </ul>	Tony Hunter, Chief Executive, SCIE Martin Smith, Chief Executive, Ealing Council
14.00 – 14.30	Coffee Break	
14.30 – 16.15	Delivering impact while tackling tricky shared challenges Thematic workshops, e.g. <ul style="list-style-type: none"> <li>• Features of good systems leadership</li> <li>• Leading and managing co-ordinated, co-located teams</li> <li>• Developing communication and engagement plans</li> <li>• Co-producing systems change with people who use services</li> </ul>	Participants to be pre-allocated to workshops, based on roles and organisation  Facilitated by SCIE/PPL
16.15 – 16.45	Next steps – exploring further opportunities for sharing learning and working collaboratively	Facilitated by SCIE/PPL
16.45	Close	

# Appendix Two: Speaker Biographies



**Martin Smith**  
Chief Executive, LB Ealing  
Chair, London Health and Care Integration Collaborative

Martin Smith is Chief Executive of Ealing Council. Ealing serves a rapidly growing population of almost 350,000 people - one of the largest in London and one of the most diverse in the country.

Martin leads on the health agenda on behalf of the Chief Executives of London's boroughs and is the Chair of the London Health and Care Integration Collaborative and in that capacity represents London's councils at national level.

Before joining the London Borough of Ealing, Martin was Chief Executive of the London Borough of Tower Hamlets in east London.

He is a member of the Chartered Institute of Public Finance & Accountancy (CIPFA) and a former Director of Resources. Martin served on the London Finance Commission established by London Mayor Boris Johnson to improve the fiscal deal for Londoners and London's businesses.

Martin is an advocate of value-led organisations and of the defining contribution of leadership to organisational performance. He is an unashamedly proud Londoner.

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**Claire Kennedy**  
Managing Director, PPL

Claire Kennedy is a Managing Director and co-founder of PPL, and a Senior Advisor on Integrating Care.

Claire has been working at the heart of the public sector improvement agenda for the past 15 years. She has extensive experience of managing complex change projects across multiple service areas, and delivering measurable benefits for customers and staff.

Claire is skilled at bringing teams of people together to deliver a shared vision for the future, and is extremely adept at working with stakeholders at all levels of organisations. Claire's role involves providing strategic development and insight across local government and health. Her particular focus is on linking strategic objectives and outcomes to everyday delivery, and the management techniques required to develop effective teams, and to enable them to maximise their performance.

Claire co-founded PPL in 2007, and has led implementation teams across health, social care and voluntary and community sectors. Most recently, Claire led on the development of local responses to the Better Care Fund (BCF), including developing the model response for the BCF on behalf of NHS England and the Local Government Association and leading the development of the resulting local transformation projects; and supporting Primary Care Transformation, through improving understanding and management of activity and demand across GP Networks.

Claire is a current Board Member and Vice President of the UK Management Consultancies Association, a member of the Institute of Directors, and a Fellow of the RSA.



**Dr Ossie Stuart**  
**SCIE Associate and Equality Diversity Consultant**

Dr. Stuart is a disabled person and from a black and minority ethnic (BME) background. He is an equality and diversity consultant with 15 years of experience as a trainer and specialist adviser. Prior to this he spent 12 years as an academic at the Universities of Oxford, York and Surrey. He has written seminal works on the experience of BME disabled people and social care.

As a trainer Dr. Stuart has provided disability and E&D training for a number of public sector organisations such as the Department of Health, a number of local authorities, universities and voluntary sector organisations. Since 2013 he has also run the annual Calibre Leadership and Management Programme at imperial College London. This is a leadership programme specifically designed for disabled employees in the public sector.

Dr. Stuart has always considered it important that disabled people have control over their own destinies. That is why he considers their involvement in the design and delivery of training key to its credibility. For example, the Calibre leadership programme that he is responsible for has been shaped, designed and delivered by disabled people. For Dr. Stuart, in E&D training co-production is the key driver for excellence.

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**Sarah Pickup OBE**  
**Deputy Chief Executive, LGA**

Sarah Pickup has recently been appointed as Deputy Chief Executive of the Local Government Association (LGA). Sarah previously worked for Hertfordshire County Council as Deputy Chief Executive with responsibility for the full range of corporate services as well as being the county's chief finance officer. Until her appointment to this role in May 2013, Sarah was Director of Health and Community Services in Hertfordshire and she had held this role since 2003.

Sarah was president of the Association of Directors of Adult Social Services (ADASS) in 2012/13, and prior to this fulfilled a number of roles for the association. In 2014 she was awarded an OBE for services to social care.

Sarah graduated from Sussex University with a degree in Economics and is a member of CIPFA.



**Tony Hunter OBE**  
Chief Executive, SCIE

Tony Hunter has been Chief Executive at the Social Care Institute for Excellence since January 2014, and is a former president of the Association of Directors of Social Services. Educated at Doncaster Grammar School, Oxford University and (for his social work qualification) Nottingham University, Tony has council experience as a frontline social worker, senior hospital social worker, training manager and manager of day and domiciliary services, as well as four years as Barnardo's Principal Policy and Development Officer.

In the early 90s Tony worked for Price Waterhouse Coopers on a range of health and social care projects before joining East Riding of Yorkshire Council as its Director of Social Services, Housing and Public Protection. As Liverpool City Council's director from 2003, Tony led the social care improvement agenda, before becoming Chief Executive of North East Lincolnshire Council in 2008.

Tony was awarded the OBE in the Queen's Birthday Honours List in 2010, for services to social care.

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# Appendix 3: About the organisers

**The London Health and Care Integration Collaborative:** Within the context of a national commitment to make integrated care and support the norm, leaders from across London came together in July 2013 to develop a London Health and Care Integration Collaborative to support the development and delivery of integrated care across London.

The Collaborative exists to champion and drive forwards progress on integrated care. Its overarching aim is to develop collective leadership to support the pace and scale of progress on integration across London in order to improve health and wellbeing outcomes for people and efficiency across the system.

The work of the London Health and Care Integration Collaborative is delivered by a small group of officers from NHS England (London), London Councils and London ADASS who work together to shape the overall programme of work and to deliver workshops and seminars aimed at practitioners and managers working to implement integrated care on the ground.

**Social Care Institute for Excellence (SCIE)** is a leading improvement support agency and an independent charity working with adults', families' and children's care and support services across the UK. It also works closely with related services such as health care and housing. SCIE improves the quality of care and support services for adults and children by:

- identifying and sharing knowledge about what works and what's new
- supporting people who plan, commission, deliver and use services to put that knowledge into practice
- informing, influencing and inspiring the direction of future practice and policy.

SCIE bids for funding from the Department of Health and other agencies. It uses this funding to develop freely available resources to improve the knowledge, skills and practice of care staff and commissioners. SCIE also provides a range of paid-for services including training, consultancy, research and product development. SCIE hosts the NICE Collaborating Centre for Social Care which develops guidelines for NICE on social care. [www.scie.org.uk](http://www.scie.org.uk)

**PPL** is a London-based independent, specialist health and social care consultancy. It works in partnership with national bodies, local commissioners and providers - and with individual patients, carers and communities – to develop, implement and realise the benefits of efficient, effective and person-centred approaches to health and care.

PPL has worked with over two thirds of local health and care economies across London and offer practical and cost-effective support across the whole spectrum of management consultancy, including:

- policy and strategy formulation
- programme design and implementation
- process reviews and target operating models
- business case development and benefit realisation
- demand analysis and customer segmentation
- evaluation and evidence
- co-production and engagement
- practice exchange and capacity building

# Appendix 4 - Delegates

**Lyndsey Abercromby**, Assistant Director Commissioning Development, NHS Camden CCG  
**Marco Adekoya**, Head of Service - Integrated Care, LB Barnet CCG  
**Lorna Blackwood**, Assistant Director, Commissioning, LB Bromley  
**Kirsty Boettcher**, Programme Director, Frailty, LBs Barking and Dagenham, Havering and Redbridge CCG  
**Jill Britton**, Head, Contracts & Commissioning ASC, LB Newham  
**Donna Bunce**, Locality Manager, Skills for Care  
**Maggie Candy**, Manager RN, Four Seasons Health Care  
**Graeme Caul**, Borough Director, CNWL  
**Gary Collier**, Better Care Fund Programme Manager, LB Hillingdon  
**Catherine Collins**, Principal Dietician, St George's University Hospitals NHS Foundation Trust  
**Shaun Danielli**, Director, Healthy London Partnership  
**Fiona Davies**, Strategic Commissioning Manger, Older People and LTC, LB Hackney  
**Stephen Day**, Director of Adults' Services, LB Ealing  
**Yolanda Dennehy**, Head, Re-enablement and Safeguarding, LB Brent  
**Nina Durnford**, Head of Service, LB Hillingdon  
**Ashish Dwivedi**, Partner Libera Partner LLP (supporting Croydon GP Collaborative)  
**David Freeman**, Director, Commissioning & Planning LB Merton CCG  
**Helen Gardiner**, Lead Financial Advisor, LB Camden  
**Jane Gateley**, Director, Strategic Delivery, LBs Barking and Dagenham, Havering and Redbridge CCG  
**Mo Girach**, Chief Executive, Partnership of East London Co-operatives (PELC) Ltd  
**Daniel Glasgow**, Business Development Manager, Partnership of East London Cooperatives  
**John Green**, Adults & Health Transformation PMO, LB Havering  
**Kirstie Haines**, Adults & Wellbeing Strategic Lead, LB Barnet  
**Patrick Hall**, Practice Development Manager, SCIE  
**Hannah Harniess**, Darzi Fellow in Clinical Leadership, NHS Greenwich CCG  
**Susan Hasler-Winter**, Mental Health Commissioning Manager, LB Wandsworth  
**Penny Heron**, Commissioning Officer, Learning Disabilities, LB Hackney  
**John Higgins**, Head, Service Safeguarding, Quality & Partners, LB Hillingdon  
**Frances Horne**, Head of Integration, NHS Ealing CCG  
**Tony Hunter**, Chief Executive, SCIE  
**Joan Hutton**, Head, Adult Social Care LB Lewisham  
**Marco Inzani**, Commissioning Lead, Better Care Fund LB Haringey CCG  
**Deborah Jenkins**, Managing Consultant, PPL  
**Amanda Jerdin**, Lead Dietician for Adult Services, Homerton University Hospital  
**Stephen John**, Assistant Director, Adult Social Care, LB Bromley  
**Meeta Kathoria**, Head of Programmes, Service Development Marie Curie  
**Claire Kennedy**, Managing Director, PPL  
**Ruth Keynes**, Senior Localities Manager London and SE, Skills for Care  
**Elisa Lakhan-Hector**, Business Solutions Architect, LB Enfield  
**Lisa Larsen**, Chief Operating Officer, PPL  
**Sandy Marks**, Chair, Personal Budgets Network & Co-Chair, Making it Real Board, LB Islington

**Claire Marsham**, Senior Strategy Manager, SWL Collaborative Commissioning  
**Joe Mills**, Associate Director of Strategy, CLCH  
**Megan Milmine**, Director, System Resilience and Integration NHS, Sutton CCG  
**Kevin Minier**, Member, SCIE Coproduction Network  
**Simon Moiroka**, Managing Director, PPL  
**Jayne Moran**, Coordinator, Islington Personal Budgets Network  
**Supriya Nerlekar**, Clinical Specialist Manager, Therapies Royal National Orthopaedic Hospital, Stanmore  
**Adam Newman-Pring**, Service Development Manager, LB Southwark  
**Ann Nutt**, Chair, Patient Panel, Princess Alexandra Hospital  
**Maria O'Brien**, Divisional Director of Operations, CNWL NHS Trust  
**Sarah Pickup**, Deputy Chief Executive, LGA  
**Emily Plane**, Strategic Delivery Project Manager, LBs Barking and Dagenham, Havering and Redbridge CCGs  
**Patricia Reid**, Imaging Core Services Modality Lead, Bartshealth NHS Trust  
**Geoff Sherlock**, Chief Officer, Adult Social Services, LB Redbridge  
**Martin Smith**, Borough Chief Executive & Chair, London Health & Care Integration Collaborative, LB Ealing  
**Bernice Solvey**, Head of Service, Adult Social Care, LB Waltham Forest  
**Iris Steen**, Head of Marketing and Communications, SCIE  
**Keith Strahan**, Programme Manager, HSCIC  
**Ossie Stuart**, SCIE Associate & Equality and Diversity Consultant, SCIE  
**Laura Stuart-Neil**, Frailty Programme Manager, UCL Partners  
**Claudia Thompson**, Assistant Director, LB Islington  
**Yvonne Toms**, Strategic Commissioning Manager, LB Hackney  
**Mandy Tottman**, Healthcare Transformation and Redesign Project Man, Independent  
**Jan Underhill**, Executive Head, Wellbeing, LB Sutton  
**Sarah Wainer**, Head of Strategy & Performance, LB Lewisham  
**Ellie Ward**, Programme Manager, City of London Corporation  
**Rebecca Wellburn**, Director of Commissioning & Planning, LB Wandsworth CCG

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