

How to... lead and manage better care



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Integration and Better Care Fund series

This series of guides was originally developed to support the mobilisation of Better Care Fund programme plans across the country. These guides continue to be of practical use to everyone involved in planning and delivering joined-up, integrated care for individuals and communities, person-centred care as part of BCF plans as well as other programmes that foster collaborative cross-system working under the new goals and ambitions of the NHS Long Term Plan. This includes frontline professionals and managers, commissioners, as well as councillors and board members in local government and the NHS, community and voluntary groups, independent providers and groups speaking for people who use health and care services.

- [How to... bring budgets together and use them to develop coordinated care provision](#)
- [How to... work together to achieve better joined-up care](#)
- [How to... understand and measure impact](#)
- [Sharing risks and benefits of integrated care: quick guide](#)
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1 Introduction

Why integration is important

Health, social care and other public services are facing unprecedented demographic and financial pressures. In just 15 years' time, the number of people over 65 is likely to have grown 50 per cent and the number of over-85s will have doubled. Demand is also growing from working-age people.

Current services are fragmented between health and social care, acute hospitals and primary and community services, and between physical health and mental health. They will increasingly fail to meet the needs and expectations of people who are living longer with a mixture of long-term health conditions and other needs that require joined-up, integrated care. The focus has to shift from treating illness to supporting people to stay healthy and independent for as long as possible. Integration is key to finding more effective and sustainable ways of achieving these goals.

The Department of Health and Social Care (DHSC) and partners within the **National Collaboration for Integrated Care and Support** agreed a definition of integrated care based on the National Voices **narrative for person-centred coordinated care** (2013) (see opposite).

<p>My goals/outcomes: All my needs are assessed and taken into account and I am supported to understand my choices and to set and achieve my goals. The needs of my family and carer are recognised and they are given support. My care and support helps me to live my life to the best of my ability.</p>	<p>My care is planned with people who work together to understand me, and my carer(s) put me in control, and coordinate and deliver services to achieve my best outcomes</p>	<p>Communication: I tell my story once, I am listened to about what works for me and my life. I am always kept informed of the next steps. The professionals involved in my care talk to each other and work as a team. I always know who is coordinating my care, they understand me and I have one point of contact I can go to with questions at any time.</p>
<p>Information: I have the information at the right time, and with the support to use it, to make decisions about my care and manage my condition(s). I can see my care records at any time and decide who has access to them.</p>		<p>Decision-making including budgets: My carer and I are involved in discussions and decisions about my care and I have help to make informed choices if I need and want it, I know how much money is available for my care and I can access this and determine how this is used or get skilled advice about this.</p>
<p>Care planning: I work with my team to agree a care and support plan – I know what it is and have as much control as I want about the kind of support I need and how I receive it.</p>		<p>Transitions: When I use a new service my care plan is known in advance and respected. When I move between services/settings there is a plan in place for what happens to me next; I know where I am going and who will be my point of contact.</p>



The Better Care Fund (BCF) was set up to drive integration between local authorities and the NHS and to pool resources to help achieve this. In 2017 it was expanded with additional money which was allocated directly to local authorities. The Better Care Fund is one part of a wider set of measures to achieve the closer integration of health and social care. Other activities include:

- **Sustainability and transformation partnerships** (STPs) have been developed in 44 ‘footprints’, aligning to health and social care economies, across England. These set out how organisations in local health and care economies can plan effectively and deliver more integrated services. Local Better Care Fund plans need to be aligned with these wider system-level plans.
- The **NHS Long Term Plan** sets out how the NHS will continue to transform and integrate over the next decade, with specific commitments over the five years to 2024 to break down the barriers between health and social care, physical and mental health and primary and acute care – the triple integration aim.

As part of this, all sustainability and transformation partnerships are expected to develop to become integrated care systems

(ICSs) by 2021. ICSs will have a key role in working with local authorities, and with commissioners making shared decisions with providers on how to use resources, design services and improve population health.

The Long Term Plan also commits to a shift towards community and primary health, with an additional £4.5 billion to be spent on primary medical and community services by 2023–24, including investment in reablement services, crisis response and enhanced health care for people living in nursing and residential care homes. Delivery of this commitment will need health and care commissioners and providers to work closely together deliver these services.

The Long Term Plan sets out the importance of local government in delivering these commitments, and many others and sets a clear expectation that local authorities should be partners in ICSs.

- **Integrated care systems (ICSs)** will be ‘evolved’ versions of a sustainability and transformation partnerships, working as a locally integrated health system. ICSs are central to the delivery of the **NHS Long Term Plan**. Within the new system, NHS organisations (both commissioners

and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health. They provide joined-up, better coordinated care. In return they get far more control and freedom over the total operations of the health system in their area; and work closely with local government and other partners to keep people healthier for longer, and out of hospital (**NHS England 2017**).

- **Integrated personalised commissioning** Building on the learning from integrated personal commissioning (IPC), NHS England published its vision for personalised care in January 2019. This includes a comprehensive model for personalised care that brings together six key components:
 - shared decision-making
 - personalised care and support planning
 - enabling choice, including legal rights to choice
 - social prescribing and community-based support
 - supported self-management
 - personal health budgets and integrated personal budgets.



There are currently 21 demonstrator sites, including three integration accelerator sites (Lincolnshire, Nottinghamshire and Gloucestershire) who are implementing this model. Learning will be shared as soon as available at [NHS England](#).

The programme includes:

- In Lincolnshire, Nottinghamshire, Nottingham and Gloucestershire, the council and the NHS are introducing joined-up assessment and personalised care and support planning for people who have health and social care needs.
- Tower Hamlets is working across health and social care to provide people with integrated provision across wheelchairs and home equipment.
- In Gloucestershire and Hampshire, the NHS and local government are working together to train staff to deliver personalised care.

Other parts of the country are encouraged to consider this approach, and how they can plan to support the roll-out of this comprehensive model including joint working to expand the use of joint assessments and care and support planning, integrated personal budgets and expand social prescribing schemes in partnership with primary care networks.

The NHS Long Term Plan builds on these ambitions – STPs will evolve into ICSs everywhere by 2021, bringing together local organisations to deliver the ‘triple integration’ of primary and specialist care, physical and mental health services, and health with social care. The Plan also proposes a major expansion of personalised care and personal health budgets. See [NHS Long Term Plan](#) (NHS England, 2019).

Tools and resources

Shifting the centre of gravity (LGA, NHS Confederation, ADASS, NHS Clinical Commissioners, NHS Providers and ADPH) is designed to support local health and care leaders to critically self-assess their ambitions and capacity to deliver integrated care. This includes the basic elements of good programme management:

- Is there an appropriate programme plan to transform the local health and social care system and make it sustainable?
- When will it happen?
- Who will lead what? And who will be involved?
- When will decisions be taken?
- When will ambitions be delivered?

- Have clear milestones and checkpoints been agreed?

Integrating care is difficult

An important lesson from over 30 years of different policy initiatives is that achieving integrated care is hard to do. However, there are certain factors that can make the difference between success and failure. These have been identified consistently in national and international evidence and research over many years and have been used to develop the structure of this guide:

- Leading a system
- Leading change
- Delivering integrated care
- Engaging and communicating

A key success factor is strong, shared and collaborative leadership, focused on outcomes that matter to people. Traditionally, senior managers have been expected to provide leadership within their own organisations, including the management of change programmes and internal communications. But integration requires change to happen across different sectors, organisations, professional disciplines and geographical boundaries.

Leadership across the whole system is needed as well as leadership within each organisation.

This guide addresses both organisational and system leadership and how this can help make local integration plans a reality. It draws on research and from practice in places around the country. It is not a step-by-step instruction manual – developing leadership should always take account of different local needs and circumstances.

The guide should be complemented by a range of implementation support tools such as workshops and online learning. The checklists included in the guide focus on the most common areas and can be used as prompts to consider other models, tools and techniques.

“I’m committed to ensuring that NHS England plays its part in shared system leadership... it’s not a few heroic individuals: it’s a different type of leadership and a more nuanced range of management skills and behaviours.”

Simon Stevens, Chief Executive, NHS England at the King’s Fund Annual Leadership Summit, November 2014

“How do you develop system leaders who see beyond the boundaries of their organisations? I think you have to do it in many ways. My senior leaders and my colleagues in other organisations have to develop a critical mass of people who believe in it, and behave it. Not all of them feel the same because they have so much going on in their own organisations that they cannot see beyond that. But when we do, we need to give people the tools and have a performance management system that requires collaborative working. So we have just put in a big learning and development programme, at the heart of which is building confidence and competency about outward-facing collaboration in our staff.”

Joanna Killian, Chief Executive, Surrey County Council

Source: **The practice of system leadership: being comfortable with chaos**. The King’s Fund (2015)

Case study: using common resources – Leeds and Salford

A number of places are seeking to look at the bigger picture by focusing on the use of their common resources, such as ‘the Leeds pound’ and Salford Together. Organisations and their leaders work collaboratively in taking decisions in place-based systems rather than focusing on what is in their own interests. In Salford, the CCG and the council have created an integrated commissioning committee to oversee the commissioning decisions for all adult health and care services across the resident population.

Source: **Leading across the health and care system: lessons from experience**, The King’s Fund (2017)



Case study: Greater Manchester – co-design and cooperation

Greater Manchester has made more progress than most, with its strategic plan having been agreed around a year before STPs were introduced in the rest of England as part of its devolution agreement with the government (AGMA et al. 2015). The plan was developed ‘on the principles of co-design and collaboration’ and is focused on people and places rather than the different organisations that deliver services. It is a practical example of the shared purpose and vision needed to underpin system leadership.

Greater Manchester has also put in place leadership and governance arrangements to support joint working. This builds on the work of the combined authority, which was formed to support system leadership across local authorities.

The leader and chief executive of Manchester City Council were central to this process and to the work now being done to engage NHS organisations in the wider devolution agenda. Frequent personal contact between leaders in local government and the NHS have helped in this process.

Source: [Leading across the health and care system: lessons from experience](#), The King's Fund (2017)

International case study: Canterbury District Health Board, New Zealand – one system, one budget

The experience of the Canterbury District Health Board in South Island, New Zealand, is a living example of what can be achieved through a long-term commitment to system leadership. Faced with a growing and ageing population, and the prospect of having to build a second acute hospital to cope with rising demand, leaders in Canterbury committed to working together as ‘one system, one budget’ even though it was neither a single system and nor did it have one budget. The district health board acted as a catalyst in this process, bringing together clinicians, managers and other stakeholders to plan services for the future.

Through an extensive process of engagement across the community, agreement was reached on a shared vision of a single integrated health and social care system in which patients were at the centre. The key strategic goals were that services should enable people to take more responsibility for their own health and wellbeing; as far as possible people should



stay in their own homes and communities; and when people needed complex care it should be timely and appropriate.

These goals were pursued in diverse ways including developing a shared electronic record and a system for managing demand for hospital care, avoiding admissions where appropriate, and investing in community rehabilitation.

None of this would have been possible if leaders in different parts of the system had not been willing to collaborate in the development and implementation of the plan. They were able to do so because of continuity in the leadership community, familiarity developed over many years, and by developing a high level of trust. Many of those involved had moved between different leadership roles during their careers and therefore understood what it was like to 'walk in each other's shoes'.

Source: [The quest for integrated health and social care: a case study in Canterbury, New Zealand](#), The King's Fund (2013)

Case study: North West Surrey

North West Surrey (NWS) has launched an integrated care programme to address the challenges faced by older people with complex health and social care needs.

They are developing a new primary care-led 'locality hub' model of care for frailty that will focus not only on providing swift reactive medical and care interventions to complex frail patients, but also on the provision of proactive wellbeing services. These will promote greater independence, improved quality of life and will prevent social isolation.

The programme has established strong sponsorship at all levels. An integrated strategic change board oversees programme delivery, while an integrated core design group with senior level representation from primary care, community care, social care, the local acute trust and mental health, oversees the design.

Strong leadership has been critical in progressing this work by bringing the necessary people together. The core design group has been meeting after-hours every two weeks to drive out the clinical model of care, and work has now started on detailed operational planning.

www.nwsurreyccg.nhs.uk



Checklist – integrating care at scale and pace

There is no single best way of integrating services but evidence and experience offer some important lessons.

- Find common cause with partners and be prepared to share sovereignty.
- Develop a shared narrative to explain why integrated care matters.
- Develop a persuasive vision to describe what integrated care will achieve.
- Establish shared leadership.
- Create time and space to develop understanding and new ways of working.
- Identify services and user groups where the potential benefits from integrated care are greatest.
- Build integrated care from the bottom up as well as the top down.
- Pool resources to enable commissioners and integrated teams to use resources flexibly.

- Innovate in the use of commissioning, contracting and payment mechanisms and use of the independent sector.
- Recognise that there is no ‘best way’ of integrating care.
- Support and empower users to take more control over their health and wellbeing.
- Share information about users with the support of appropriate information governance.
- Use the workforce effectively and be open to innovations in skill-mix and staff substitution.
- Set specific objectives and measure and evaluate progress towards these objectives.
- Be realistic about the costs of integrated care.
- Act on all these lessons together as part of a coherent strategy.

Source: [Making integrated care happen at scale and at pace](#), The King's Fund (2013)

2 Leading a system

Leading across boundaries

Many of the best examples of successful integration in the UK and abroad began with partners developing a shared vision about what they want to achieve and the benefits for local people.

This involves honest conversations about differences and how these can be managed – for example, the ‘soft’ issues of different professional cultures and ways of working as well as the ‘hard’ differences between governance, accountability and financial and performance regimes. A good test of effective joint working is how well partners manage their differences without jeopardising what they are trying to achieve together. This is the essence of systems leadership.

Systems leadership describes the way people need to behave when they face large, complex, difficult and seemingly intractable problems where:

- no one person or organisation can find or organise the solution on their own
- responsibilities are overlapping or unclear

- they need to juggle multiple uncertainties
- resource pressures necessitate a joint approach to managing demand.

The way forward therefore lies in involving as many people’s energies, ideas, talents and expertise as possible.

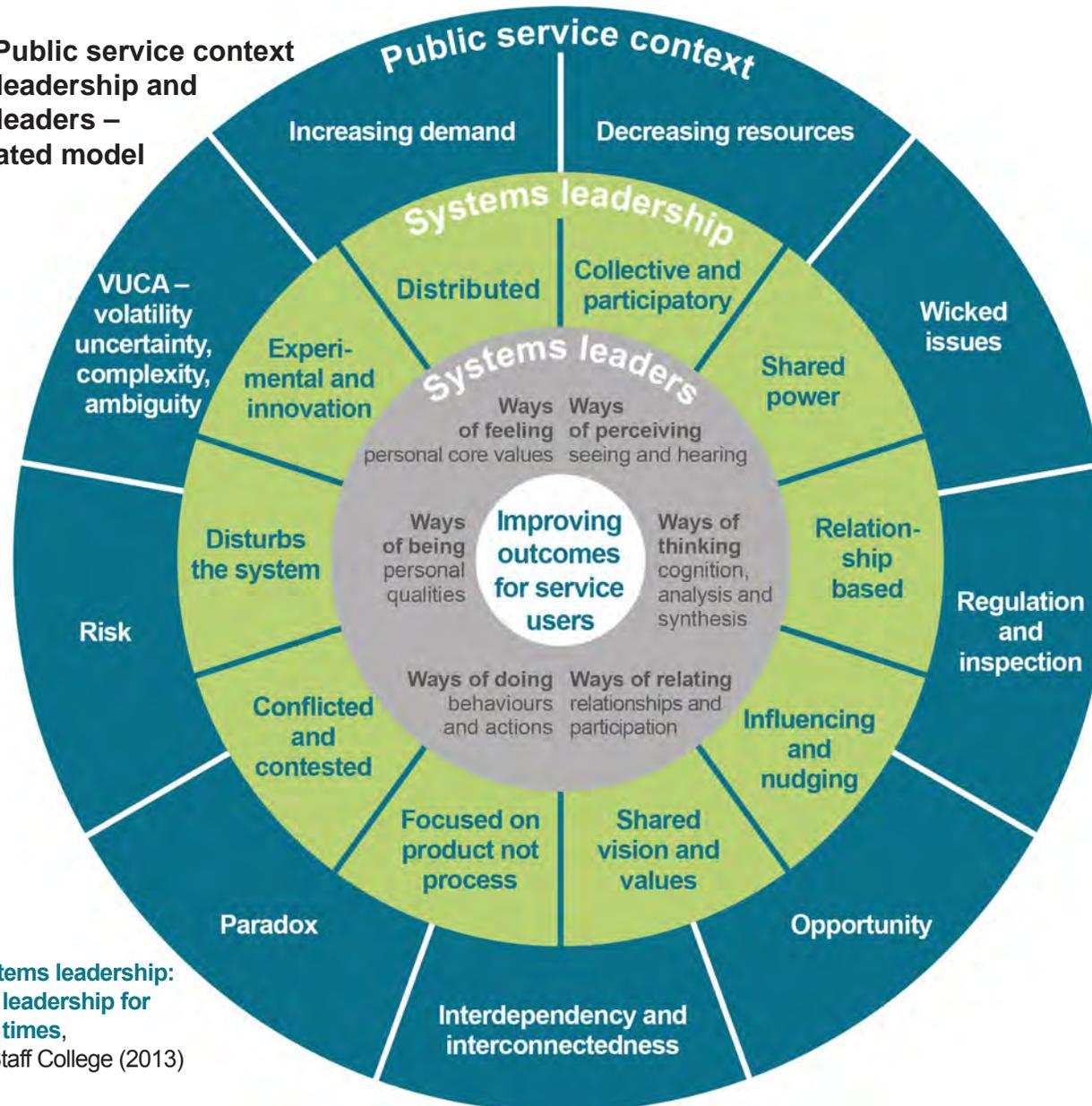
Systems leadership is particularly relevant for people involved in the delivery of health and care services, and in integrating complex services around individuals. The aim of systems leadership is to transcend individual organisational interests and work together on the basis of a shared ambition, with a view to making progress towards better health and wellbeing outcomes across a population. It is a practical, grounded approach to integrated working.

This is not to portray systems leadership as some kind of silver bullet or magic wand. But evidence of its benefits is growing and it will be hard to implement effective integration without it.

“*Whole system transformational change will only occur if we have the right leadership in place. We have found it invaluable to have [systems leadership] mentoring/coaching support for the senior leadership team... Through the Pioneer programme we have had an experienced programme enabler who brings board members together to reflect, share and challenge – we know that if we want to shift the workforce to a new ethos and culture, we need to start at the top.*”

Clare Henderson, Director of Commissioning, NHS Islington CCG and NHS Haringey

Figure 1 Public service context systems leadership and systems leaders – an integrated model



Source: **Systems leadership: exceptional leadership for exceptional times**, The Virtual Staff College (2013)

Further information

Over the past three years, there has been a national systems leadership programme including a research programme into what makes for good systems leadership; the development of joint leadership development programmes open to people across sectors, and place-based support to some 40 integration and population health projects across the country. The most recent **evaluation** of these ‘local vision’ projects describes the benefits in most places of developing a systems leadership approach to ‘wicked’ issues, including bringing together stakeholders, engaging professionals and improving services and outcomes for people.

“Establishing good relationships is fundamental to joint working and should not be underestimated; listening to others, trust, openness – all need to be nurtured.”

Cheshire Local Vision project: developing multi-agency response to social isolation



Shared values

Systems leadership goes beyond partnership or collaboration, because it is not just about retaining the power and authority of an individual leader while working with others. Because of the complexity of the issues involved, systems leadership recognises that leadership is not vested solely in people because of their job titles or authority, and works on the basis that leadership and influence are distributed. It therefore involves being willing to cede leadership to others if they are in the best position to provide it, and coming together not on the basis of a single pre-identified solution, but on the basis of a wider shared ambition or purpose – for example, for a group of people who use services. Systems leadership welcomes partial, clumsy or emergent solutions, and supports experimentation, working with uncertainty and adapting as you go along.

Systems leadership behaviours therefore include:

- focusing on outcomes and results rather than processes
- basing the work on strong but honest relationships

- allowing for experimentation – and therefore allowing for risk
- being willing to genuinely listen to others and see their point of view
- being able to adapt, going with ‘good enough’ solutions and building on them rather than waiting until you have the perfect service/solution.

At the heart of systems leadership in practice are shared values and intentions to improve outcomes for people who use services. This core is surrounded by complex, if interrelated, dimensions. Although they overlap, these dimensions can be categorised as:

1. Personal core values (ways of feeling).
2. Observations, ‘hearing’ and perceptions (ways of perceiving).
3. Cognition, analysis, synthesis (ways of thinking).
4. Participatory style (ways of relating).
5. Behaviours and actions (ways of doing).
6. Personal qualities (an overarching way of being that forms the essence of both professional and personal style and approach).

Systems leadership is best seen as a mindset, or a way of thinking about and approaching the leadership role, rather than a set of technical skills or competencies.

The National Voices website has a helpful summary of **Systems leadership for beginners: what it is, how it works, and why it helps**.



Checklist: five factors that facilitate effective system leadership

- Develop a shared purpose and vision of what future services should look like.
- Have frequent personal contact – to establish the rapport and understanding on which collective leadership hinges.
- Surface and resolve conflicts – difficult truths should be confronted not suppressed.
- Behave altruistically towards each other – ask not ‘how can I win in this discussion?’ but rather ‘how can we succeed together?’
- Commit to working together for the longer term – because of the investment of time and energy needed to build effective relationships.

Source: [Leading across the health and care system - lessons from experience](#), The King's Fund (2017)



Case study: Mid-Nottinghamshire's outcomes framework

In Mid-Nottinghamshire, commissioners have developed a single outcomes framework to measure improvements in the wellbeing of the population and in system performance. The framework aims to enable providers to work together to deliver a set of common goals and use resources more effectively. It should encourage innovation in how providers deliver services, since it focuses effort on improving outcomes rather than inputs or processes.

Commissioners developed the framework in a working group bringing together representatives of the local authority, local doctors, and Healthwatch. They also carried out engagement activities involving 400 people across Mid-Nottinghamshire. They have focused on developing a set of outcome measures that reflect what is important to people who use services and how services can help them meet their personal goals.

The framework includes four domains: measures of population health such as premature mortality; overall quality of life (including independence and management of conditions); quality of care (including patients' experience of care); and the effectiveness of care, including immediate and longer-term recovery. The framework includes indicators to allow commissioners to monitor system performance, in particular: to monitor shifts in activity from hospital to the community; to identify areas where activity is decreasing, and allow commissioners to challenge providers if they are restricting access to care; and to measure financial sustainability. It also includes indicators to allow commissioners to monitor how providers are transforming care, such as the proportion of patients with up-to-date care plans or levels of social prescribing as an alternative to medical care. The aim is to avoid setting measures that will overly constrain how providers deliver care.

Commissioners are now aligning contracts with the framework. They are working with providers to agree a baseline of performance and trajectories for improvement, so that they can establish financial incentives linked to the outcome measures.

Source: [New care models – Emerging innovations in governance and organisational form](#), The King's Fund (2016)

3 Leading change

Successful leaders of change display four key attributes – they are visible, resilient, inspire a sense of purpose and have grip on the key information and facts.

This section focuses on the attributes of leadership that need to be embedded in successful teams. This is aimed not only at system leaders but at anyone in a leadership role. There are several different models of leadership development, including the NHS national framework, **Developing people improving care**. This includes systems leadership skills for leaders improving local health and care systems, whether through sustainability and transformation partnerships, vanguards or other new care models. These skills help leaders to build trusting relationships, agree shared system goals and collaborate across organisational and professional boundaries. Resources for leadership development are also available through **The Leadership Centre** and **The King's Fund**.

Being visible

Most change fails during the transition from old to new. One crucial factor is that staff in an organisation need to 'keep believing' that the change will improve the lives of people who use its services. The leader's role should not be underestimated in giving staff the confidence to continue. A leader should:

- ensure their role and responsibilities are clear and explicitly shared
- communicate the vision for integrated care widely and regularly across partners and with the population
- show that by pursuing integration, other objectives are achieved as a by-product
- personalise the integration work, so that it resonates with all audiences (including staff, people who use services and the wider public).

Showing resilience

- Leaders should be prepared to take and explain difficult decisions. Many integrated care plans require decisions to be made that can have short-term impact on some organisations. Great leadership will be resilient and find a way through this conundrum to achieve the longer-term prize of integration.
- Working in an integrated way across many organisations has been a challenge for health and care systems. Leaders need to work hard to build trust and a common purpose for integrated care. One successful way to achieve this is by focusing on a particular area of need or priority that resonates across organisations. The improvement of outcomes for frail older people or those at high risk of hospital admission is a good example. The key message from successful systems is that leaders need to be persistent to keep driving forward the vision for service transformation. Organisations where the leadership is seen to have lost interest and moved onto new priorities will quickly lose impetus.

Inspiring shared purpose

- Leaders should be seen to live the values that underpin the local vision for integrated care. They should act as role models for people across your local system.
- It is important to maximise the contribution of the teams to improve the quality of the Better Care work. Workloads should be spread across people who are already stretched.
- A leader needs to demonstrate the importance of Better Care to them, within their organisation and across the local health and care system. This is often overlooked and the role of the leader is to constantly remind people of the Better Care goals to improve population health and wellbeing.

Model: Engaging frontline staff – Lankelly Chase system changers programme

The ideas, experience and commitment of front line professionals are crucial to implementing effective integrated care. Lankelly Chase have run a system changers programme in a variety of public service environments with the aim of enabling frontline workers to contribute to and create systems change. The programme has generated five principles about how this can be done:

1. Create time and space. Frontline workers need time and opportunity to think about how their system is working and how it could be improved.

Question: Do you offer those in frontline roles time or opportunity to contribute to thinking about how their system is working and how it could be improved? Do people have any space outside of their delivery role? Do you allow people flexibility in their roles to make decisions and changes or do you lock things down in process?

2. Disperse power. Give explicit permission to staff to question how your system is working, don't assume that people will speak up if things aren't functioning well

Question: Are you aware of how power is distributed in your organisation? Do you give explicit permission to staff at all levels to question how your 'system' is working with a view to improving it? Do you have genuine feedback loops in place that enable real dialogue rather than bottom-up feedback?

3. Take down language and evidence barriers. Break down 'official language' and jargon and accept new forms of evidence. This will level the playing field for those wanting to create change.

Question: Do you communicate in jargon and official language more than you need to? What space and encouragement do you give to voices that speak in non-official language or without a cost-benefit analysis? Do you give enough validity to different types of evidence? Are you aware of the labels you use and the impact they have?



4. Nurture community. It's very hard to make change happen alone. Help staff form peer relationships to support each other.

Question: Do you enable staff to form peer relationships and communities to support each other? Do you encourage interaction beyond people's official roles?

5. Model system change behaviour. Wherever you sit in an organisation, take on some of the ways of being and doing what we've just described.

Question: Do staff at all levels demonstrate system change behaviours? Do they engage with a range of different perspectives? Do they show that it is ok to try and fail when making change to improve things? Do they act outside of 'hierarchies' or seek to reinforce them?

Source: **'From where I stand' How frontline workers can contribute to and create systems change: A report on the 2016 Systems Changers Programme**, Lankelly Chase (2017)

Having a grip on the key information

Leaders should select a small number of measures that act as an 'acid test' of local progress in implementing integrated care. The leadership role is to keep the system's partners focused on a few key metrics, which reflect the goal of organisations working in joined-up ways to achieve better outcomes and experiences for service users. Two examples are the achievement of local Better Care Fund plans in reducing permanent admissions of older people (aged 65 and over) to residential and nursing care homes; and increasing the proportion of older people still at home 91 days after discharge from hospital receiving reablement or rehabilitation services (**National Audit Office** 2017).

The best metrics for a local system need to align in a meaningful way with the vision and strategy for integrated care. The **SCIE Logic Model** is a good place to start when confirming how a local system's various partners and services are intending to work together and clarifying what the system is expected to achieve – from improving people's experiences of care to delivering better coordinated and more preventative

services close to home in local communities. This leadership consensus will then drive local priorities and aid in the selection of relevant metrics. It's important to consider using a combination of routinely collected data from national sources as well as local indicators.



Measuring effectiveness of health and social care integration

In its Integration and Better Care Fund Policy Framework the Government confirmed its plans to develop a wider integration scorecard – which would combine outcome metrics, user experience and process measures – to help areas understand whether they are meeting its integration ambition, especially at the interface between health and social care.

The Department of Health and Social Care and the Ministry of Housing, Communities and Local Government worked with stakeholders to develop a performance dashboard. The dashboard provides a set of measures indicating how health and social care partners in every local authority area in England are performing at the interface between health and social care. You can find out more at [Local area performance metrics](#).

The Care Quality Commission has produced and is regularly updating [Local area data profiles](#). These profiles give a picture of the health and social care system in each local authority area. They bring together data to give an indication of how different services work together.

Tools and resources

Coaching and peer-to-peer support can help leaders to check their leadership impact and reflect upon and improve their performance.

Tools on leadership style can help people gain insight into the impact of their particular leadership style (e.g. **360 tool provided by the NHS Leadership Academy**).

The revolution will be improvised: stories and insights about transforming systems (the 'Systems Leadership – Local Vision' programme) draws on insights from 25 multiagency programmes around the country to discuss how people break or make collaboration and service transformation, and what we can learn from their experiences.

The Leadership Qualities Framework (Skills for Care) describes the attitudes and behaviours needed for high quality leadership at all levels across the social care workforce. It focuses on the values and behaviours that provide the foundations for effective leadership in social care.

Checklist for leadership of change

The governance for sign-off and resourcing is clear.

- A strong narrative led by the leadership team is in place.
- There is an explicit approach to leadership development.
- Leaders are visible and resilient.
- Tough decisions are made and communicated in a timely way.
- Leaders are able to contribute to system leadership as well as leadership of their own organisations, driven by a shared commitment to integrated care.
- Commitment to deliver integrated care is sustained beyond the first flush of enthusiasm.
- Key metrics are used to assess and drive local progress.

In my experience it is important to think about outcomes for patients, carers and populations, not targets, cultures not structures, place not organisation, delegation not transfer of functions and clinical and professional engagement.

Andrew Cozens CBE, former Strategic Adviser, Children Adults and Health Services for the Improvement and Development Agency for local government, and President of the Association of Directors of Social Services (ADSS) in 2003/2004



4 Delivering integrated care

Overall arrangements

Effective programme management and governance is crucial in translating the local vision for integrated care into a practical plan that delivers discernible improvements and better outcomes for individuals and the local population.

Good governance should offer structured programme oversight that brings together all relevant organisations in a focused, collaborative way to support the shared vision for integrated care and how this will be achieved.

Local areas have considerable flexibility in how they implement integration, but there are several national initiatives that contribute to this goal. Programme management and governance arrangements should therefore show how each programme contributes to the overall delivery of integrated care for individuals and the local population. As a minimum:

- national reporting and assurance process requirements for each national programme should be complied with

- ensure that there is clear strategic alignment between integration-related plans – including the STP/ICS plan for implementation of the NHS Long Term Plan, BCF Plan and Joint Strategic Needs Assessment
- the development of new care models should be an integral part of the local vision for integrated care, not a separate add-on
- the opportunities for individuals to integrate their own care through local integrated personal commissioning programmes, although on a smaller scale, should not be overlooked.

Areas should benchmark themselves against the **Stepping up to the place: self-assessment tool** to identify the strength of local leadership and maturity of health and social care integration in their area.

Programme management

The role of the programme management officer should focus on achievement rather than activity for its own sake, ensuring the programme board has the concise and focused information it needs to understand progress against schedule and budgets, and to recognise and manage the risks and issues that could limit progress.

Good programme management is about understanding and contributing to a vision and then building and organising a committed, skilled team to deliver specific objectives that will realise that vision. A well-managed programme will have a constant dialogue with system leadership over its objectives, priorities and progress. There will be difficult decisions to be made over priorities, and trade-offs will have to be conducted between time, cost, scope and quality. Issues will crop up with disaffected stakeholders or around funding availability. Risks around information availability or financial incentives will have to be actively managed.

All this requires a senior and experienced individual who understands the programme vision and plays an active role in shaping the

programme to deliver that vision. This person needs to be credible among managerial and clinical leaders from across the system, able to quickly build a good knowledge of the main content issues, and to understand the difference between administrating and managing a programme. The programme manager understands and shapes the content of the programme rather than being a mere administrator of the plan. They have a meaningful dialogue with stakeholders in shaping the programme, actively build a team that can deliver the programme, and work closely with the communications lead to craft and deliver the story of the programme.

“
Achieving a shared purpose and clear vision has been key to getting so many people involved in so many sectors. Achieving this has taken time, with many iterations of the vision and challenges of “we do this already” and “it will never work”, but the time invested in this has led to a greater clarity and commitment.

The thorough way we approached planning at the beginning is now starting to result in benefits. Because our programme was an iterative process based on testing things and learning from them, without a solid framework, we would have struggled to keep on track.”

The Local Vision programme in South Tyneside describes what effective programme management has meant.

Checklist: programme change

Objectives and rationale

- Specific objectives have been set for projects within the overall programme, rather than vague aspirations.
- The objectives for individual projects clearly underpin the overall programme vision and will realise that vision for people who use services.
- Rationale, business case and benefits of each project are clear, be they financial, clinical or patient experience (e.g. ‘we are doing this because it will...’).
- The costs of implementing each project are clear, and so are the ongoing operational costs.
- The objectives and rationale are well communicated and understood by key stakeholders across organisations (see section 5).



Prioritisation and resourcing

- Projects are clearly prioritised according to a sound logic that is understood and accepted by key stakeholders. There are only a small number of priorities at any one time.
- Each prioritised project is properly resourced with a team that has the skills and time availability to get the job done – people are dedicated full time where they need to be.

Structuring the programme

- The programme and sub-project organisation structures are clear. Wherever possible, direct control is given to the programme manager, for people across all organisations involved in delivering the programme.

Managing the plan, reporting issues and risks

- There is a meaningful milestone plan, at a suitable summary level, that the programme board understands and influences.
- The plan covers all elements needed to deliver (e.g. IT, estates, workforce etc.).

- Project management office reporting is concise and to the point, and directs stakeholders towards understanding and tackling the issues that stand in the way of progress.
- Issues and risks are clearly identified and addressed by the programme board – especially how risks are shared across organisations.

Governance

- The programme board actively promotes a culture that is positive, inclusive and transparent. It is receptive to engagement and open to information sharing.
- All relevant organisations are involved in the process even if they are not formal members of the programme board. This includes commissioners, providers (NHS and independent social providers), voluntary and third sector organisations, Healthwatch and other groups representing people who use services. The programme board is seen as a 'go to' place to make things happen and meetings should be well attended.

- Representatives are sufficiently senior and represent the view of their organisations. They are empowered to make decisions, subject to statutory ratification.
- Terms of references are clear and set out powers of decision-making and recommendations.
- The decision-making process is clear and consistent, describes how conflicts can be escalated or resolved and is followed in practice.
- Real risks and issues are being discussed and resolved within the programme board.



Case study: governance – North West London (NWL)

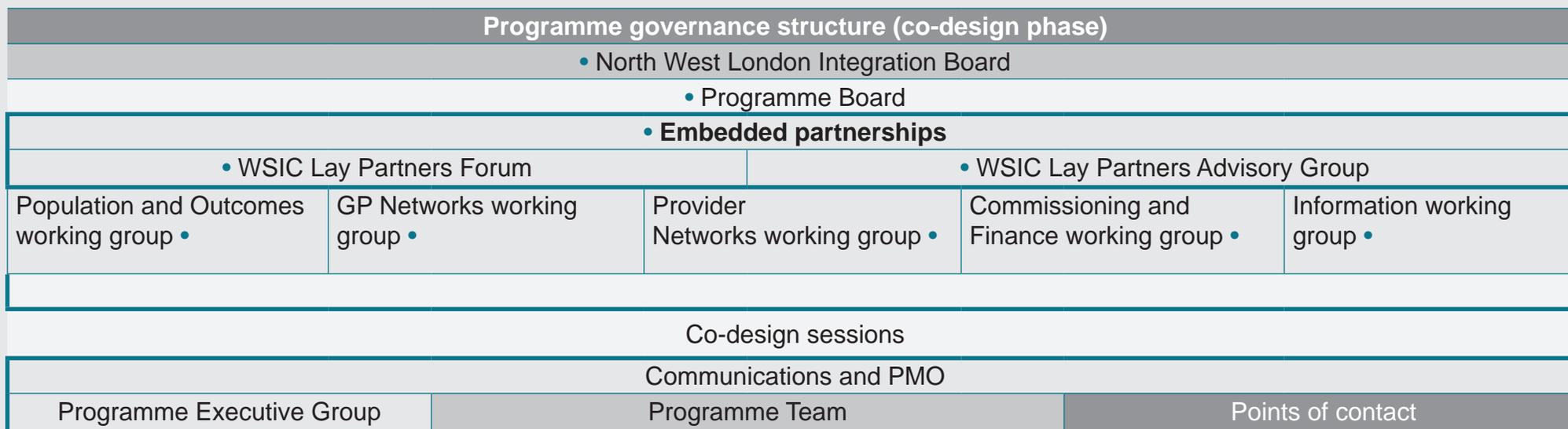
The NWL Whole System Integrated Care programme has incorporated ‘lay partners’ (people who use services and carers from across the population in NWL) into every layer of its programme governance structure to ensure co-production is embedded throughout.

The cornerstone of the co-design process was the set of working groups that were

held across five modules to address the central questions of integrated care design for North West London.

A working group was established for each module which consisted of an equal partnership between lay partners, clinicians, commissioners and care professionals to co-design the future of integrated care. Throughout this

programme, the focus was on the importance of incorporating both the professional expertise of the clinicians and care professionals and the holistic lived experiences of the lay partners. There was lay partner representation on each one of the module working groups, and everyone worked as equal partners throughout the programme.



• Lay partner representation

Reproduced from [North West London Whole systems integrated care toolkit](#)



Case study: strategic commissioning in Northumberland

In Northumberland, health and social care commissioners are planning to develop a more strategic approach to commissioning. Under the new governance arrangements, the health and wellbeing board will continue to oversee public health and social care commissioning and the wider system. Meanwhile, the CCG board will continue to oversee and make final decisions on health funding and will monitor system performance.

A new joint commissioning unit will support both these boards and oversee the accountable care organisation, which is likely to be a partnership between Northumbria Healthcare NHS Foundation Trust (the acute, community and adult social care provider), Northumberland, Tyne and Wear NHS Foundation Trust (a mental health provider) and general practice.

The unit is expected to maximise opportunities for joint planning across public health, health and social care, and to make best use of much smaller

commissioning teams. Under the proposals, commissioners will focus on a narrow range of more strategic issues. These include: setting the high-level outcomes it expects the accountable care organisation to achieve; allocating funding to the accountable care organisation and to a small number of separate services; monitoring outcomes and performance, and intervening where there are significant concerns about performance; overseeing public engagement; and, in some cases, making final decisions on major service change.

Meanwhile, commissioners envisage transferring almost all of the annual £400 million budget for core services to the accountable care organisation, which will be a partnership of its acute, mental health, community services and primary care providers. Northumbria Healthcare is likely to formally hold the contract for managing the health budget. However, the intention is for the other providers to work in partnership to manage the budget and manage risks.

Finally, the CCG intends to transfer staff to the provider system to carry out a range of more tactical activities, including developing the contracts and overseeing the performance of individual services.

Source: [New care models: Emerging innovations in governance and organisational form](#), The King's Fund (2016)



Case study: Connected care programme in Berkshire West and Frimley

Building on work initiated by the local CCGs, Berkshire West ICS and Frimley ICS have been working together to improve information-sharing across primary, acute, mental health, community and social care services. The programme brings together records from across the organisations involved – 18 health and social care organisations and 135 GP practices – into a shared care record, giving health and care professionals instant access to information about their patients drawn from across the system. It is supported by an IT system that collects and makes accessible information from the range of IT systems used.

The system went live in January 2018. A website has been created to inform patients and the public about how their information is being managed and how they can express their preferences in relation to information-sharing, and there are a range of materials on the programme available from the organisations involved. The budget is £10.8 million over five years, and is drawn from a range of sources,

including £600,000 from the Better Care Fund. The longer-term ambition includes improving patients' access to their information through a portal, and enhanced population health analytics capability, to support priority-setting and targeted support.

Source: [Digital change in health and social care](#), The King's Fund (2018)



Tools and resources

As detailed earlier, **Shifting the centre of gravity** (LGA, NHS Confederation, ADASS, NHS Clinical Commissioners, NHS Providers and ADPH) is a self-assessment tool designed to support local health and care leaders to critically self-assess their ambitions and capacity to deliver integrated care. This includes the basic elements of good programme management.

The **Integration resource library** (Local Government Association) signposts local areas to evidence, case studies, tools and resources which will support the development of integration ambitions locally.

Making an impact through good governance: A practical guide for health and wellbeing boards (Local Government Association) discusses the contribution of health and wellbeing boards to the local delivery of integrated care and includes examples and case studies.

Managing organisational change in adult social care (SCIE) is an online resource to support managers in care services, local authorities and integrated health and social care services. It explores managing change through case studies of managers in different settings.

5 Engaging and communicating

Strong engagement and communication with a wide range of people and organisations throughout the health and social care system is vital for the successful delivery of Better Care.

Meaningful involvement of staff, people who use services and their carers can help ensure that new approaches are well informed and sustainable.

Create a narrative for coordinated care

Many places have used stories about how integrated care will offer individuals a better experience and outcomes. One example is Torbay's **Mrs Smith**. Other places have developed their own versions, but most have in common a clear description of what the change means for the individual and the benefits it brings. Good narratives tell a clear story of why the change is required, what will have to change and what improved outcomes will arise by when.

To develop a strong narrative:

- Include people who use services and carers as experts by experience. Draw on powerful stories and insights. Since the success or failure of the programme will be judged on local experience of joined-up care, transformation plans should be built on the experience of local people. This will also help to build a brand for local integration to encourage sign-up and commitment (see **Principles for integrated care**, National Voices).
- Articulate what 'better care' and 'integration' actually mean in practice. Build commitment across the partnership with individuals using the **I-statements** from the National Voices narrative to clearly set out what they will do differently to achieve the vision. This could follow the example of **Leeds** by including high-level commitments from system leaders.
- Make the narrative tangible by integrating agreed performance metrics. Ensure objectives are realistic and discussed with people who use services and carers.

- Be realistic and honest with stakeholders – do not overpromise what can be delivered and recognise the boundaries of the project.



It is important to create a compelling story which everyone at all levels across the economy can associate with and take themselves back to when they are facing a challenging situation to remind themselves that this is why we are on this journey.

Cheshire Local Vision project:
developing multiagency response to social isolation



Use a common language

- Create and share a clear and common language that will be used in all communications. Everyone involved in delivering the programme should adopt this shared language and use it to disseminate messages. Ensure this is aligned – both across the health and care system and with other associated initiatives, for example personalisation.
- Revisit the narrative frequently to help ensure that people adopt the shared language and test it on people who use services and staff. Opportunities could include partnership meetings, multidisciplinary teams, community engagement events, team meetings and training sessions.
- Use joint and clear branding of all information, avoiding jargon and acronyms – or use the NHS Confederation’s acronym buster to explain.

Case study: the importance of local context – Salford

Salford clinical commissioning group (CCG), Salford Royal NHS Foundation Trust and Salford City Council have been working together to develop an integrated care programme to meet the needs of a fictional but typical resident – Sally Ford – and her family. Similar approaches have of course been adopted earlier and successfully in Torbay (Mrs Smith), Jonkoping (Esther) and elsewhere. While these all use the device of a person as a means of engaging communities and stakeholders around individual needs, it is worth noting that Sally Ford is from Salford. She speaks with a Salford accent, lives in a Salford street, travels on Salford trams. This then is an example of adaptation as much as of adopting good practice from elsewhere.

Source: [System leadership: Lessons and learning from AQuA’s Integrated Care Discovery Communities](#), The King’s Fund (2014)



Develop clear measures of success

- Communication strategies need to identify clear outcomes and measures to track performance. Understanding the impact of different engagement activities will help refine the approach and focus on the most effective techniques.
- Frameworks such as logic models or **theory of change process maps** can help plot the logical links between the main communication and engagement activities, their immediate outputs and the short-, medium- and long-term outcomes.

Understand your stakeholders

- Identify all of the internal and external stakeholders who need to be involved and obtain sign-off from the programme board.
- Explore and surface the core motivators for different stakeholders, understand their stance on integration and develop approaches which address their particular issues or concerns.
- Do not overlook hard to reach and **seldom-heard groups**.
- Remember that everyone has a communication role, including people who use services and local groups. Map the different ways in which stakeholders interact to identify good opportunities to communicate messages. Identify champions from across the health and social care economy that can play a communication role.

“We work in a knotted ball of string, where you have to be comfortable talking to chief executives one day and patients and health care assistants the next, and where you know it is not linear like a railway track. There are lots of branches off on the way. It is about persuading, not ordering, asking not telling, everybody’s equal – that sort of thing. You have to be comfortable with chaos. And it does need a different sort of manager with different skills, not the tub-thumping showman who needs to be centre stage. You need to have people who can make connections and relationships, and that’s a totally different set of skills.”

Jan Vaughan, Associate Director,
Cheshire and Merseyside Strategic
Clinical Networks

Source: **System leadership: Lessons and learning from AQUA’s Integrated Care Discovery Communities**, The King’s Fund (2014)



Equip people with the right communication skills

- Offer training and support to communication champions, including people who use services.
- Include communication training in existing training and development programmes, including staff induction.
- Include communication-related objectives in appraisal processes.

Engage local people

- Develop a wider a strategy for engaging with the wider public – use Arnstein’s ladder of participation (see box) to think through the purpose of engagement and the outcomes that are being sought.
- Co-develop and co-produce communication plans and engagement strategies with people who use services, carers and families.
- Create opportunities for feedback from stakeholders, including people who use services, carers and communications champions. Routinely monitor feedback and review narrative, engagement and communication plans.

“ ... in terms of success, one in North West London has been genuine co-production with lay people ... So that is a big success. And more people seeing that whole system integration as the way that we are going to solve the problems that we are in. So in terms of critical mindset changes, I think that those are successes. Failure would be if we don’t let go and allow our enabled local areas to move forward at a pace that is right for them – so the fastest move forward more quickly. ”

Thirza Sawtell, Director of Strategy and Transformation, North West London Collaboration of Clinical Commissioning Groups

Source: **The practice of system leadership: being comfortable with chaos**, The King’s Fund (2015)



Engage local politicians

Understanding how to create a public narrative that works to secure buy-in and support from local politicians – usually elected local councillors – is essential. Consider the following:

- If providing information and advice to enable a complex decision, try to provide genuine options with associated risks and implications.
- Be clear about what the elected councillor is trying to do (e.g. make a decision, scrutinise the executive, deal with a ward resident's query, represent a community group) and provide the right type and amount of information to help them to do it. If unclear; ask, do not just assume.
- Show understanding and respect for politicians' very different world, for example, ask questions about issues arising at ward level, show that you see issues from their vantage point.
- Have elected members' confidence that your input is politically neutral – word travels fast otherwise.
- Show a readiness to use elected members' personal knowledge and expertise (they have lives outside politics!) and make the most of their familiarity with the places and people they have been elected to represent.
- Never let an agreed deadline go by without response – if there is a delivery problem, explain what can be done by when (the politician may need to let others know what's happening).



Ensure engagement and communications are joined up

Presentations should be delivered jointly by leaders from across the health and social care system, with engagement of people who use services and carers wherever possible. Communications need to look and feel joined up.

Leaders in this role should:

- agree roles and responsibilities to ensure a consistent and comprehensive approach to engagement
- refer to the same narrative, and use the agreed common language
- agree answers to frequently asked questions and provide joint contact points for questions and answers (e.g. on websites and e-bulletins)
- use case studies and examples that accentuate joint working
- co-produce and co-deliver the communications and engagement plan with people who use services, using a broad range of methods and approaches – see **Co-production: What it is and how to do it**, SCIE

- involve non-executive colleagues from both health and local government (e.g. elected members, NHS trust non-executive directors and clinical commissioning group lay members). The LGA's **A Councillor's guide to the health system** is a useful introduction to respective roles in the NHS and local government
- think creatively about which communication formats or channels can be used to reach a wide audience and maximise engagement.

Case study: key success factors for My Life a Full Life programme in the Isle of Wight

Figure 2 Example of how to creatively communicate the programme vision From My Life a Full Life programme on the Isle of Wight



- People who use care and support need to be made aware of the programme.
- Targeting and marketing the narrative is essential to success.
- Engagement and a clear communications strategy are needed at the earliest possible stage.

For more information please contact MLAFL@iow.gov.uk



Checklist: effective engagement and communications

Effective engagement and communications strategies can draw on the following tools:

- Simple tailored messages (e.g. **Five things that every councillor should know about integration** – LocalGov article).
- Visual aids (e.g. **Telehealthcare in Hants infographic, Hampshire County Council/PA Consulting/Agenti**).
- Video and animation (e.g. **Maggie and Rose's Story – Joining up care in Islington**, by The Young Foundation).
- Stories and personal accounts to demonstrate how people's lives will be changed: (e.g. **Patient stories, North Manchester Integrated Neighbourhood Care Team**).
- Online dialogue platforms.
- Posters and reminders (e.g. **Celebrate an 85 Birthday at Home display**, Portsmouth).
- Existing channels (e.g. correspondence with current people who use services, review meetings etc.).

The ‘Ladder of Engagement and Participation’ – reproduced from NHS England

There are many different ways in which people might participate in health, depending on their personal circumstances and interest. The ‘Ladder of Engagement and Participation’ is a widely recognised model for understanding different forms and degrees of patient and public involvement (based on the work of Sherry Arnstein). Patient and public voice activity on every step of the ladder is valuable, although participation becomes more meaningful at the top of the ladder.

Devolving	Placing decision-making in the hands of the community and individuals. For example, personal health budgets or a community development approach.	Devolving
Collaborating	Working in partnership with communities and people who use services in each aspect of the decision, including the development of alternatives and the identification of the preferred solution.	Collaborating
Involving	Working directly with communities and people who use services to ensure that concerns and aspirations are consistently understood and considered. For example, partnership boards, reference groups and people who use services participating in policy groups.	Involving
Consulting	Obtaining community and individual feedback on analysis, alternatives and/or decisions. For example, surveys, door knocking, citizen’s panels and focus groups.	Consulting
Informing	Providing communities and individuals with balanced and objective information to assist them in understanding problems, alternatives, opportunities and solutions. For example, websites, newsletters and press releases.	Informing



Tools and resources

A year of integrated care systems: reviewing the journey so far (King's Fund, 2018): examples and case studies from existing integrated care systems.

Engaging local people – a guide for local areas developing sustainability and transformation plans (NHS England, 2016) addresses expectations on stakeholder involvement, in particular patient and public participation.

Integrated care: local partnerships to improve health and care (NHS England, 2018) includes information about sustainability and transformation partnerships and integrated care systems.

NHS England's involvement hub includes a variety of resources on patient and public involvement, including bite-sized guides to participation, governance, payments and expenses, and engaging with specific groups.

A new relationship with people and communities (The People and Communities Board, NHS England) describes how individuals and communities can be more closely involved in developing person-centred health and social care.

Integrating health and care – a must know guide (LGA) highlights the key issues for elected members on integrated care.



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