Local Health Systems:
Relationships not structures

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Foreword

Looking at health and care through a systems lens reveals a wealth of connections and opportunities to achieve better outcomes, as seen in the case studies within this paper.

Systems are also complex and changing, with multiple inputs and feedback loops, and control distributed across multiple stakeholders. This paper is a timely exploration of the strategies, skills, and toolkit for effective working within systems.

The paper is particularly focused on local government's role in health and care systems, though there are learning points relevant to any systems leader. The breadth of local government's responsibilities, and its key role in care provision, suggests that this is where the greatest opportunities lie.

Local government is also the point at which citizens will most frequently connect with public services forming part of our health and care systems. Systems run on feedback, and so this intersection is essential to responding to needs at place.

All of this has implications for leadership at all levels and in all parts of health and care systems. Leadership in systems is certainly a practice, and not a position, and through the research carried out by LGIU, we see here key features of effective leadership.

I've spent a large part of my time in recent years with internal and external colleagues exploring what integrated care systems will look like and how to prepare for their introduction (not to mention speculating on when that would happen!). But I've always considered it essential to spend time on the 'why' too – the outcomes we're tying to achieve for citizens, service users and workforce. In my experience that's what inspires and excites and will ultimately produce a system that is understood by those working in it and using it while delivering the best outcomes.

It has been a pleasure working with LGIU, to take what feels to me like a natural next step and explore what effective leadership within these evolving health and care systems will look like, and what we can do to maximise their ability to meet the purpose for which they exist.

James Arrowsmith
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Introduction

Local government either has a statutory responsibility for, or an influence on, much of what drives good health, including decent housing, environmental planning, education and skills provision, economic growth, and public health, as well as social care for adults and children. But to achieve the goals of improved long term outcomes across communities will require a step change in the role that councils play within local systems for health. To do this, we need both renewed local leadership and an adequate supply of funding.

The aim of thinking about local government in terms of systems is to build a more connected approach across places that drives towards a set of coherent and mutually supportive social and policy outcomes. In this paper we seek to develop an understanding of local government's role within systems for health and wellbeing. Based on interviews with council officers in three areas of England, we show that there is huge potential for system wide partnerships, especially following the Covid-19 pandemic. We find that there is a widespread appreciation of the value of system-based policy, of partnerships, risk taking and innovation. Yet these often do not play out in practice.

What is stopping the adoption of system thinking?

Some key barriers have held back progress towards greater integration across systems, including:

- A culture of risk aversion among many in leadership positions;

- A chronic shortage of capacity within local government;

- A broken funding system for councils

- Institutional disconnect between agencies involved in health and wellbeing.

Systems thinking aims to take seriously the complexity of issues that public policy seeks to address. Solving many policy challenges requires much more than one agency acting independently, or pulling a lever to "apply" an intervention. It relies on partnerships between people and organisations, between public and private sector. It needs a shared understanding of goals and approaches, of strong dialogue and access to information. But it also requires the capacity to use that information, to build the relationship that collaboration depends on, and an appetite for taking risks that enables innovation.

But the debate among policy makers can often be skewed towards the structure and processes of the systems thinking, and lose sight of the outcomes and objectives. This is especially true of the debate about English devolution, which has been dominated by a narrow focus on reorganisation of council governance. The question of whether to adopt wholesale unitarisation across local government seems to have enjoyed more consideration than a deeper and more important question about how to achieve better outcomes for people. Indeed, the current government had for a long time planned to publish a white paper on devolution.

This was delayed repeatedly, before it changed shape and became a "levelling up" white paper. This was also delayed until 2022. While the paper did contain a detailed diagnosis of some of the problems, it did not provide a convincing solution.

Instead of a relentless focus on structural reform, councils would be better served by thinking about the objectives they are aiming for and how they can act effectively within complex systems: working in places and with partners. Indeed, based on the interviews conducted for this report, we would argue this sort of understanding is a prerequisite of successful devolution. The incongruities between local government and the health focussed parts of the system, such as the NHS, are manifest in culture and behaviour, as well as structure and governance.

Public policy is all too often framed by process and structure that aims to minimise risk, rather than achieve goals. Local government regularly falls into this trap too. Aversion to risk and an emphasis on oversight and control has set boundaries on the level of ambition and innovation that might be pursued locally[1]. Existing approaches, even those that are failing, are often maintained, while short term interventions that address immediate demands can take precedent over more long-term, system-wide collaborations that may help to tackle the underlying causes of complex problems.

To move away from a culture of risk aversion and siloed, short-term approaches to policy problems, the debate needs to abandon the fixation on structure. Instead, we argue in this paper we need to look at two important factors:

1. Leadership: We need the leadership that enables coordination across local health systems. That means developing a culture that values strong relationships, shared responsibility for outcomes, and an appetite for risk taking and innovation. Local authorities and other public agencies, including NHS trusts, CCGs, health and wellbeing boards, as well as new Integrated Care Partnerships, need to front up to the challenge and provide this system wide leadership.

2. Funding: The English model for funding local government is woefully inadequate and a consistent barrier to strategic action that improves health outcomes across different regions. This is a problem of scale, in that there is just not enough funding available, given the increase in demand and reduction in grant over the past decade. But it is also an issue of how that funding is delivered. We need to move on from the piecemeal, *ad hoc* and short term patchwork of ring-fenced pots that Whitehall makes available to councils for capital spending. Strategic planning for health requires stability and capacity. It cannot be done on a shoestring.

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1 Collaborate (2020) Reframing Risk https://collaboratecic.com/reframing-risk-c7bc54285dda

Recommendations

In order to support change in these two areas, we make the following the recommendations:

Make sure that all partners' strategic documents are aligned across the system. Strategic priorities and the documents that are set out to govern how organisations collaborate are crucial. They are not the end point, but along with trust and transparency in conversations between partners, these documents can be the basis of system-wide change. Getting the strategy right and making sure it is aligned is essential.

Work closely with citizens. The shift from structures to relationships should go hand in hand with a shift from services to people. The population should be the starting point. Listening to citizens is also a crucial tool for understanding the impact that interventions have across the public realm. They can provide crucial evidence for or against policy decisions, and direct experience of how different parts of the system connect, or how they don't.

Balance risk. It is important for commissioners to develop the right balance between risk aversion and risk acceptance. There can be good reasons for risk aversion, particularly as councils often cannot afford mitigation, or there may be strong evidence against risk. Yet this should be balanced with the need to try new approaches and to collaborate with partners, which can present the risk of getting things wrong.

Create the conditions for behaviour change. We often talk about behaviour change being the solution to many policy problems. But it won't happen by itself. Within organisations, such as local authorities, leaders need to provide the right framework and incentives for staff to behave in certain ways. They need to create the conditions for trust and collaboration, aligning incentives and performance indicators accordingly so that staff feel safe enough to look around them, taking a system-wide view of the work that they do. This also requires a set of skills that may not be widespread or recognised, such as listening.

System-wide budgeting. Funding should be provided specifically for the coordination of strategic priorities across the system. Various models of single pot place-based financing, going back to Total Place, have been tried and shown to have positive impacts.

Build capacity. Capacity is already stretched in local government and in the NHS. Additional responsibilities for long-term strategy and partnership building should not impose greater demand on local authorities without decent and reliable support. System change cannot be done on a shoestring.

1. Systems

In this section, we introduce the concept of systems thinking and place the practice within the local government context. We explain what systems thinking is, how it could work in local government, how it may help in the development of health and social care provision in particular, and how it relates to moving responsibility and power over policy areas through devolution. We end by outlining case studies of systems thinking implementation.

According to the OECD 'Complexity is the core feature of most policy problems today'[2]. Indeed. complexity is a core feature of many of the policy issues that local government is grappling with today. Yet, many local authorities, health services and other public sector organisations are ill-equipped to deal with complex problems. These wicked problems have multiple causes, both long and short term, and they require interventions from different agencies across the public sector, including local government, but also the private sector and within communities themselves[3]. Traditional analytical tools and problem-solving methods no longer produce the desired outcomes[4]. So how do we, as a sector, manage increased complexity, account for uncertainty, and deliver services that are able to dynamically adapt to the needs of our clients?

Conventional policy making in local government addresses the social problems that we aim to tackle as discrete problems, making discrete interventions which work alongside or are layered on top of one another. This is the so-called "frog view" in which 'public servants start to concentrate heavily on selected technical details' that can be controlled and delivered in some way, 'creating a false sense of certainty and purpose of action'[5].While this approach may work for simple problems, it fails to acknowledge the complexity of contemporary problems and can lead to gaps in effectiveness and the failure to enable long-term solutions.

New ways of thinking, such as systems thinking allow us to go beyond this approach by embracing the complexity of the problems that we are dealing with. Looking at the whole, multifaceted system that impacts upon a complex problem, rather than just parts of it, enables us to see how we can make changes that will have the greatest impact on the lives of people we are working to improve.

Changing how we think about and work through problems isn't easy when the pressure to provide consistent high-quality public services remains. We hope that this report explains what systems thinking is, practical steps that can be taken to implement it in your organisations and how it can work to improve the way we approach complex problems.

What is systems thinking?

Systems thinking is a way of approaching problems and organising processes that is based on an idea of integration that is grounded in the belief that in a system,

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2 https://www.oecd.org/publications/systemic-thinking-for-policy-making-879c4f7a-en.htm
3 "What Can Policy-Makers Get Out of Systems Thinking? Policy Partners' Experiences of a Systems-Focused Research Collaboration in Preventive Health" Int J Health Policy Manag 2020, 9(2), 65–76
4 OECD (2017) Working with Change: Systems Approaches to Public Sector Challenges, OECD, pp. 1- 122
5 https://www.oecd.org/publications/systemic-thinking-for-policy-making-879c4f7a-en.htm

component parts act differently when isolated from other parts or the system environment.[6] It allows us to understand the dynamics and properties of the complex systems in which we work[7], and what kinds of interventions can lead to better results.

In a sense, systems thinking is a perspective on what is going on. It can involve a unique vocabulary so can be thought of as a language too. Finally, as it offers a range of techniques and devices for understanding, capturing, and communicating about systems, it is also a set of tools.[8] It is this final, very practical, aspect of systems thinking that we concentrate on in this report. While there is a great deal of theory about systems, it is only when the behaviour of commissioners and officials changes to accordingly, to take the system view into account, that it becomes useful.

Systems thinking is not about theory, it is 'a way of seeing and talking about reality that helps us better understand and work with systems to influence the quality of our lives.'[9] Once we understand how systems work, and our own role in them, we function more proactively and effectively within them. Similarly, the more we understand systemic behaviour, the more we can anticipate that behaviour and work within the system for improvements.

What is a system?

A system is 'any group of interacting, interrelated, or interdependent parts that form a complex and unified whole that has a specific purpose'. The most crucial feature of a system is the interdependency of the separate parts, without this, we wouldn't have a system, just a collection of parts.[10]

Defining features of systems

Purpose: every system has a purpose that provides integrity and definition to the unit. The purpose is a property of the whole system, not the component parts.

All parts serve a function: all parts of the system should be integral to its functioning. It shouldn't be possible for the system to work without one of the parts, or for it to function exactly the same if additional parts are added.

Order is important: this is another feature which demonstrated the difference between collections and systems. In a collection, it doesn't matter in which order you combine the parts. In a system, the arrangement of the parts matters a great deal and has a big impact on the outcome.

Stability through feedback: feedback provides information to the system which lets it know how it is doing relative to the desired outcome. This information then allows the system to change course if necessary.

Systems thinking can help people and organisations to see the overall patterns, structures, and cycles in systems, rather than their own narrow responsibilities.[11]

6   https://learningforsustainability.net/systems-thinking/
7   OECD (2017) Working with Change: Systems Approaches to Public Sector Challenge
8   Kim, D.H. (1999) Introduction to Systems Thinking, Pegasus Communications Inc, pp. 1-21
9   Ibid
10 Ibid
11 https://learningforsustainability.net/post/complicated-complex/

When problems are encountered, they are addressed in a way that not only solves the narrow issue, but also leads to improvements throughout the entire system.

Types of problems

Simple problems	Complicated problems	Complex systems	Wicked problems
Basic techniques and understanding of terminology may be required	Complicated nature based on larger-scale problems and increased need for coordination or specialised knowledge	Cannot be understood solely by simple or complicated approaches to evidence, policy, planning and management	Unique problems that need unique solutions.
High level of assurance of success	After one successful outcome, there is a relatively high degree of certainty of further successes	Formula have limited application	No end to the number of solutions or approached that could be adopted as possible solutions.
		Experience of previous complex systems is useful but uncertainty of outcome remains	

Systems thinking in a local government context

Systems thinking has been applied to the public sector context since the early 2000s.[12] A 2004 Demos paper *System Failure* (2004) argued that government can no longer do policy making in a simple, linear way:

"Systems thinking, which treats public services as complex adaptive systems, offers an alternative route to developing solutions and increasing system performance.

A key insight from systems theory is that different individuals and organisations within a problem domain will have significantly different

12 Summers, P. (2010). "Systems thinking in local government. 2010 UK Systems Society International Conference- Perceptions of Systems: the Nature of Management, Communication & Creativity. Accessed online: https://www.researchgate.net/publication/262414620_Systems_thinking_in_local_government

perspectives, based on different histories, cultures and goals. These different perspectives have to be integrated and accommodated if effective action is to be taken by all the relevant agents.

In the local government context, John Seddon's Vanguard approach to systems thinking (see table below)| has been the most influential. This approach is based upon a three-stage iterative process called Check-Plan-Do. We will see in the case studies section below how this approach works in reality.

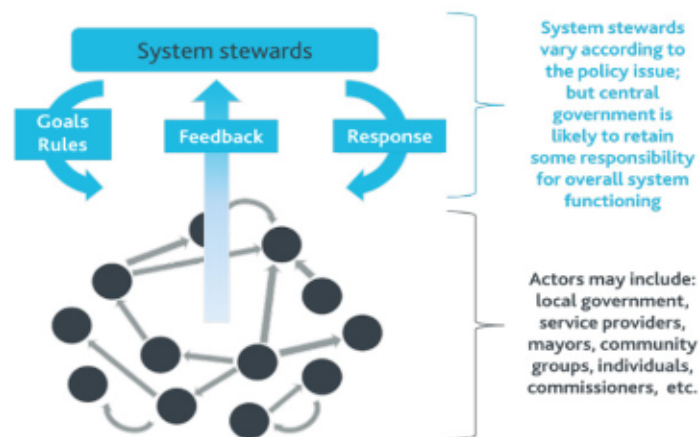| Stage in process	What is it?	What does it do?
Check	An analysis of the what and why of the current system.	Provides a sound understanding of the system as it is and identifies potential causes of waste. What is the purpose of this system? What is the nature of customer demand? What is the system achieving? How does the work flow? Why does the system behave like this?
Plan	Exploration of potential solutions to eliminate waste.	Provides a framework to establish what the purpose of the system should be and how the flow of work can be improved to meet it. What needs to change to improve performance against purpose? What action could be taken and what would be the predicted consequences? How should success be measured and against what?
Do	Implementation of solutions incrementally and by experiment.	Allows for the testing and gradual introduction of changes whilst still considering further improvement. Takes the planned action and monitors the consequences against purpose.

Source: Seddon, 2005, p.20

Health and care systems

Recent years have seen an increase in calls to approach public health problems using systems thinking.[13] This approach of looking at complex issues is ideal as a number of different agencies are involved on multiple levels of interaction with individuals that affect their health and wellbeing. Some have called for a conceptualisation of health that recognises and embraces all the separate elements that can affect a person's wellbeing.[14]

The Institute for Government's paper *System Stewardship* argued that the separation and sequential relationship between policy making and delivery is misleading. Instead 'there needs to be a greater understanding of the complexity and unpredictability associated with any intervention.' Policy interventions can produce unpredictable and complex effects, which suggests, firstly, that feedback loops are important for targeting interventions towards desired outcomes and, secondly, that localised coordination is necessary to align actors and actions within a system. The paper, which was written in 2011, went on to argue that changes to increase local leadership of systems might add to complexity:

> *"Decentralisation is likely to mean that these actors gain more autonomy, increasing levels of unpredictability - but also allowing a more responsive, sensitive approach to policy problems."*

Figure 2: System stewardship in practice

System stewards

Goals Rules — Feedback — Response

System stewards vary according to the policy issue; but central government is likely to retain some responsibility for overall system functioning

Actors may include: local government, service providers, mayors, community groups, individuals, commissioners, etc.

Source: Institute for Government

Devolution

Decentralisation is an important part of this process as it can enable actors to adapt and respond to their local environment. Policy directives from Whitehall are often disconnected between departments. The funding and strategies are not aligned on a place-basis. It is down to local leaders, usually local authorities, to coordinate and reconcile differences in local areas, bringing together agencies and the communities so they work towards shared goals.

13 Allender, S., Brown, A.D., Bolton, K.A., Fraser, P., Lowe, J., Hovmand, P. (2019) 'Translating Systems Thinking into Practice for Community Action on Childhood Obesity', Obesity Reviews 20(S2), pp. 179- 184
14 Sniehotta, F.F, Araujo-Soares, V., Brown, J., Kelly, M.P, Michie, S, West, R. (2017) 'Complex. Systems and individual level approaches to population health: a false dichotomy?' Lancet Public Health 2(9), pp. 396-397

However, the devolution debate has been dominated by opposing arguments about governance structures. The relationships and skills on which system leadership is founded have been neglected. As such, adaptability and responsiveness to complex conditions has been neglected. Appropriate levels and institutional boundaries for governance reform has been privileged at the expense of the actual interaction of networks and communities that create conditions on the ground. In short, the debate has been shaped around what is convenient for politicians and policy makers in Whitehall, not building on local strengths and practices.

Barriers to local government systems leadership?

There are barriers that make it harder for local government to play a strategic role within systems. These are echoed in the interviews we undertook for this report.

- Capacity and resources.
- Skills.
- Organisational cultures and behaviours.
- Risk aversion.
- Accountability to central government.
- Limited powers.
- Infrastructure for sharing and assessing data. How can you have an effective feedback and adaptation mechanism if information does not flow where it is needed in the system?

These barriers are explored further in the following section, which draws on the experiences and perspectives of local authority officers.

2. What the sector thinks: interviews with policy officers in three local government areas

To understand what the local government sector thinks about health and care systems and their role within them, we interviewed 10 policy officers from local authorities in Essex, Lincolnshire and the West Midlands. Interviews were semi-structured and conducted on the basis of anonymity.

This section presents the main findings of that research.

Relationships, not structures?

The importance of honest and high-trust relationships was the strongest and most consistent theme from our research. Leaders stressed the investment of time and effort required to build trust and mutual understanding – there are no short cuts. Being able to appreciate issues from the perspective of people in other roles and organisations is key.

A senior public health officer from the West Midlands said that 'Relationships are the basis, but at the moment we are not all working towards a common goal.' They said that the key is 'getting people around the table together', continuing that it is 'a new era for local authorities' and that 'Commissioning in future can't be transactional, we're realising that we've all got skin in the game'. This means that 'we need to engage in a different way' both within the council and with partners. Reflecting on the changing form of engagement another interviewee told us that 'Consistency is important, but so is adaptability over time'.

Leadership and culture are important, and the West Midlands public health officer said they have a strong culture that starts with the leader: 'it's all one team and one problem that we share, but have got to get this down to people on the ground to ensure they see it as their responsibility too'. According to the public health director from a district in Essex 'People have to buy into this long term, so we have to understand what is in it for each partner':

> 'Our communications team needs persuading of the value of this way of working. They need to help promote the understanding that this is the day job now. Our objectives can no longer be delivered just through the council.'

This is an issue of governance: 'we try to promote distributed leadership, so that people take on change and responsibility themselves', but it also means understanding the council as one player within the wider system for health and developing the culture to act accordingly.

An officer in an Essex district described some of the differences that have taken shape in their council's culture:

> 'In traditional partnerships the person who organises or convenes usually takes away the bulk of responsibilities or actions. In our partnerships we have dispersed leadership, so the responsibility and action is shared.'

The officer from the East Midlands said that emotional intelligence is a key ingredient and a necessary skill for staff: 'You need to bring people along with you, it's about hearts and minds'. There are constraints on councils' ability to work in this way, however. An officer from one of the Lincolnshire districts cautioned that 'Resources are a problem, people don't have the capacity to do this work'.

Looking to the near future, the district service director in Essex said that 'the impact of the Health and Care Bill should be positive on our partnerships, positive recognition for the role of districts and other agencies in the area'.

New focus since pandemic

The Covid-19 pandemic had a huge impact on how councils perceive health and wellbeing, as well as relationships with the community.

A senior public health officer in the West Midlands said 'the pandemic has shown that services are an incredibly important part of this wellbeing'. They argued that this should change councils' approaches permanently, asking 'Why could I do this systems stuff then, during the pandemic, but not now?'

An officer from Lincolnshire said the pandemic has increased the proactive focus on changing outcomes. They have regular meetings with the voluntary sector now and are 'very aware of the impact of pandemic and government policies on people'. The council has pulled inequality data into one place so they can assess where there are pinch points across the district and better understand the links between deprivation and services like end of life care.

A council in the West Midlands was particularly proactive in working with NHS providers to boost vaccine uptake in the area. An officer told us 'The NHS is responsible, but I am calling on the NHS to be more mobile and to get out there into communities. It's worth their while if some people are coming and it's low risk.' The council took on the risk of underwriting the programme and ensure there were funds for promoting vaccine take up. They hired a bus that went out into communities, and provided jabs for local people.

A public health officer in a district in Essex said they felt that they had more positive relationships with the county council in recent years:

> 'at county level they are listening to local need a lot more now and we are much better connected with social care and other areas at county level. Services are distributed. Now these relationships are really strong and the path we are on is a good one.'

We were told about the Prevention Enablement Model, a pilot public health programme across Essex that aims to boost physical activity as a means to improving population health, independence and community development. The pilot has 'has enabled risk taking, because we don't need so much assessment from within the council'. The pilot involves partnerships across the community and a profit sharing relationships with leisure providers. An officer told us that 'as well as the risks involved in acting, we have to consider the risks of not doing it, too'. This creative approach to community level action and partnerships for a range of

health outcomes is feeding back into the district council, we were told:

> *'previously the community development work was siloed and vertically organised and didn't really work. Now we are making it horizontal, community development is what the whole organisation does'.*

That being said, an officer told us that 'changing culture is happening slowly, especially focussed on support for the community'.

Barriers

There are some major barriers that prevent a more widespread and strategic systems focus within the public sector.

Three sets of challenges emerged from our interviews: **funding**; **capacity**; and **institutional disconnects**.

1. Funding

The scale and shape of funding is a serious barrier to embedding local government practice within systems for health and care. As things stand it is finance for local government, rather than strategic, system-wide planning, that governs what councils do. That funding is based on central government grants, which have been cut back over the past decade, and a patchwork of ring-fenced funding pots.

Several of our interviewees told us this makes long-term and strategic planning extremely challenging. One, from Essex said "Government funding streams are a barrier, they don't allow themselves to be used strategically". A policy officer from a district in Lincolnshire told us that:

> *"The change to bidding for funding under the coalition government doesn't help with this. It is better in other European countries which have more core funding for local services".*

> *"We don't necessarily have the opportunity handed to us now. Systems need long term thinking, which is not there at the moment."*

2. Capacity

Lack of capacity is a further barrier that councils have come across.

The officer from an Essex district said "Councils are too cash-strapped to think strategically, though this is probably easier in larger metropolitan areas. We just don't have the resources and we can't afford strategy officers.' Another officer, from the East Midlands, said 'if we had more resources we would look at all systems but not able to'.

However, a public health officer in Essex said that thinking about systems can help to overcome capacity issues: 'the systems approach means that we can work both hyper-locally and bring the county into discussions, maximising the capacity'.

3. Institutional disconnect

Systems for health involve a complex network of institutions and the differences in structure and culture can be a significant barrier to developing a system-wide approach. The NHS plays a leading role in health systems, but, as one strategic director from an Essex district said, "I've never had the sense that the NHS has been open to systems conversations". Working within a system suggests a horizontal, collaborative approach to solving problems. But many of our organisations for health and wellbeing are vertical, both in their organisational structure and culture, but also in the way they provide services. An officer from a district in Essex told us that "there is no culture of strategic thinking in the UK". Another asked "What's the point of implementing systems thinking in a system that doesn't lend itself to this way of working?"

The policy officer from a Lincolnshire district told us that "data sharing is difficult, organisations think they can't share data". They went on to say that while sharing data about children is easier, it is difficult with adults, especially around domestic abuse cases. Furthermore, because families move about, often across institutional boundaries, it is important to have the relationships and system in place to keep track. Again, there are capacity issues around data, as "resources are needed for people to analyse data and come up with actions."

Attitudes to risk

One important element of institutional disconnect is found in increasingly divergent attitudes to risk taking between different parts of the public sector.

A head of service in a Lincolnshire district council said that their officer leadership is largely risk averse, particularly when it comes to finances. Having said that, the council has made large investments in housing and communities. Another Strategic officer from an Essex district said that:

> 'The risk appetite in the council is fairly low. It requires a step change in thinking, while at the moment people are retrenching and focussing on the default view of what we are here to deliver in terms of services. They are largely small "c" conservatives.'

A senior public health officer in the West Midlands argued that:

> '[the pandemic] has shone a torch on different areas link together, and the importance of sharing and pooling risk, building up our appetite for taking risks. Why should we go back to a "manageable risk" attitude? This in itself involves a big risk.'

They said system-wide working 'needs a jump of risk, as part of a partnership' and argued that it 'requires political appetite so that even when something is not working we try again and take a different approach'. A senior officer from an Essex district council said that

> 'our attitude to risk taking has changed. There used to be much more appetite for risk, but capital projects which have gone bad have seen an

end to this. We are more risk averse now, but it does depend on the local politicians in charge at the time. Politicians are more willing to take risks than officers, particularly if they know they will be politically popular.'

A senior officer in another Essex District said discussed the effort to shift the council's attitude to risk: 'We are moving away from the bureaucratic focus on risk assessments and moving beyond the "it's not our problem" attitude.'

Another described this change as part of a shift towards system-based working: 'There was a risk of embarking on this change: were we ever going to see the benefits? But it was about making a case for our role within the system.

3. Shifting sand – a recent policy history of local health integration

Successive governments have promoted greater integration between health and social care. Initiatives such as joint commissioning and pooled budgets go back decades. In this section we look at the reforms various governments have undertaken in health and care over the last decade, of which the move towards Integrated Care Systems and Organisations is the most recent. We propose some questions for local government to consider during the implementation of this latest round of reform.

The Heath Foundation says that integrated care in the NHS is broadly used to mean one of two things: more joined up services (for example, community care teams involving both health and social care professionals) and more closely linked organisations such as NHS organisations working between one another, or NHS organisations working with non-NHS organisations.

Integration between health and social care is part of the wider context of integration, including integration across the NHS – between hospitals and primary care; the NHS and social care; and physical and mental health.

NHS reforms have developed a new landscape for health planning and delivery framed around large geographical footprints; first, sustainability and transformation partnerships, then integrated care systems, which developed into the levels familiar today:

- integrated care systems

- places – often equivalent to a shared clinical commissioning group (CCG) and local authority area, or part of the footprint for a large council

- primary care networks – partnerships between GP practices which aim to involve community health and care services – generally around 30,000 to 50,000 people

- neighbourhoods and communities – smaller areas where people may have specific health and care needs. (Health Foundation)

History and legislative context since 2012

Health and Social Care Act 2012

The Health and Social Care Act 2012 brought in the most wide-ranging reforms of the NHS since it was founded in 1948. On 1 April 2013 the main changes set out in the Act came into force, and most parts of the NHS were affected in some way.

Part 1 sets out a framework which confers NHS functions directly on the organisations responsible for exercising those functions, while retaining a general duty on the Secretary of Health to promote a comprehensive health service. It also gave local government a new set of duties to protect and improve public health.

Clinical Commissioning Groups (CCGs) were established and Strategic Health Authorities and Primary Care Trusts abolished. Health and Wellbeing Boards were introduced.

> 'At local level, local authorities will have a much stronger role in shaping services, and will take over responsibility for local population health improvement.
>
> New Health and wellbeing boards will bring together local commissioners of health and social care, elected representatives and representatives of Healthwatch to agree an integrated way to improving local health and well-being.
>
> Most NHS care will be commissioned by clinical commissioning groups, which will give GPs and other clinicians responsibility for using resources to secure high-quality services.'

<div align="right">(Department of Health and Social Care factsheets on the Act)</div>

Care Act 2014

The Act was a landmark piece of legislation, but it is accepted that its principles have not been realised. Sajid Javid, the Secretary of State for Health and Social Care, acknowledged this in his introduction to the recent adult social care white paper: 'We recognise that the ambition of the Care Act has not consistently been achieved in the way we would have liked'.

The Act:

- Placed a duty on local authorities to promote an individuals' well-being, including unpaid carers, when making decisions.

- Embedded an individual's right to choice, placing focus on their needs and what they want to achieve, and a legal right to a care and support plan.

- Placed a duty on local authorities to provide or arrange services to keep people well and independent and help prevent people developing needs for care and support, and delay people deteriorating such that they would need ongoing care and support arising from a physical disability, mental impairment or mental illness.

- Placed a duty on local authorities to ensure that their local care market is healthy and diverse.

- Introduced a duty on local authorities to assess unpaid carers needs for support.

Five Year Forward View 2014

The *Five Year Forward View* focused on the greater integration of healthcare providers to offer a more joined-up service for patients. Accountable Care

Organisations (ACOs) were established as a means to help deliver this.

In August 2017, a draft ACO contract was published, which allowed Clinical Commissioning Groups (CCGs) to choose to commission ACOs in their areas.

Accountable care organisations are a model of integrated care - integrating primary, secondary, and community care for a large defined geographical area, and operating under one capitated – a set amount per head – budget, run by one organisation.

Accountable Care Organisation was a provider of general practice, wider NHS and potentially local authority services that enters into an ACO contract with the commissioner of those services. The ACO is a 'lead' provider organisation, 'accountable' through clear contractual obligations for the integration of services. ACOs were not new types of legal entity, but provider organisations awarded ACO Contracts.

Sustainability and Transformation Partnerships (STPs)

STPs were introduced in the NHS planning guidance December 2015 in a new planning framework for NHS services. STPs were intended to be a local blueprint for delivering a transformed health service set out in the Five Year Forward View.

NHS organisations were required to agree with local government partners a STP planning footprint. The guidance says that this should be based on 'natural communities, existing working relationships, and patient flows and take account of the scale needed to deliver the services, transformation and public health programmes required, and how it best fits with other footprints such as local digital roadmaps and learning disability units of planning'. It also says that STPs should build on existing arrangements such as devolution or the Success Regime.

There was criticism from local government that the sector had not been properly involved in the development of the model. There was also a lack of alignment with council boundaries and with HWBs own plans for integration.

NHS Long Term Plan January 2019

In the NHS's Long Term Plan, new service models were announced to promote integration, Integrated Care Systems (ICSs). The main aim of ICSs is to integrate care across different organisations and settings, joining up hospital and community-based services, physical and mental health, and health and social care. All parts of England are now covered by one of 42 ICSs.

The Kings Fund argued that:

> 'ICSs are part of a fundamental shift in the way the health and care system is organised. Following several decades during which the emphasis was on organisational autonomy, competition and the separation of commissioners and providers, ICSs depend instead on collaboration and a focus on places and local populations as the driving forces for improvement.'

ICP contracts bring together a range of services under a single contract and provider (previously Accountable Care Organisations).

The King's Fund suggest that there is no blueprint for developing an ICS and 'in contrast to many previous attempts at NHS reform', national NHS bodies have so far adopted a relatively permissive approach, allowing the design and implementation of ICSs to be locally led within a broad national framework. This has resulted in significant differences in the size of systems and the arrangements they have put in place, as well as wide variation in the maturity of partnership working across systems:

> 'This approach leaves some uncertainty around what the end state of the changes will be, and variation across the country can make these reforms more difficult to understand. However, the advantage is that it enables systems to create arrangements that are suited to their local context and build on the strengths of their existing relationships and local leadership.' (King's Fund)

The LGIU published a series of viewpoints on the proposed changes. There are many helpful measures in the LTP that consolidate significant shifts in how the NHS operates that have been taking place incrementally over the last few years (see LGIU policy briefing on the LTP (members only)). Among these are a recognition of the importance of working with local government to develop place-based approaches, an increased focus on the importance of outcomes over activity and more action on prevention and tackling health inequalities. All these, and more, make a good basis for the vision of place-based health and care.

However, there have been concerns from health and care experts that top-down reorganisations will be counter-productive. The structural measures in the LTP may not be full top-down requirements but there is a new NHS landscape with some major changes taking place.

One aspect of the new arrangements is the blurring of the distinction between commissioning and providing. There is, though, a danger (in the relatively small number of large providers in the NHS taking more responsibility for system-wide outcomes) that this might result in the most bullish NHS organisations wanting to 'provide the whole system' in the name of collaboration – potentially rolling back positive partnerships with weaker partners in the NHS and the voluntary, community and social enterprise (VCSE) sector.

Health and Care Bill 2021-22

The Health and Care Bill has wide-ranging provisions, many of which concern how NHS organisations work more effectively together.

Subject to the passage of the Bill through Parliament, ICSs will have two statutory components: integrated care boards (ICBs) and integrated care partnerships (ICPs).

ICSs which have been operating as voluntary partnerships will be placed on a statutory footing in July 2022 and they will cover every part of England.

'Each system will be made up of two new bodies: 'integrated care boards' (ICBs)—area-based NHS agencies responsible for controlling most NHS resources to improve health and care for their local population—and 'integrated care partnerships' (ICPs)—looser collaborations between NHS, local government, and other agencies, responsible for developing an 'integrated care strategy' to guide local decisions. Clinical commissioning groups will be abolished and their functions taken on by the new ICBs.'
(Health Foundation)

Each ICS will have an integrated care board responsible for NHS and wider integration, and an integrated care partnership responsible for promoting health, care and wellbeing and developing an integrated care strategy. Each ICS will also comprise of place-based partnerships and joint arrangements at locality level through primary care networks.

ICS's four overarching aims are:
- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

ICS's will take over commissioning GP services from CCGs in July 2022 when CCGs will be disbanded. Some will also take on dental, ophthalmic and pharmaceutical commissioning then, with all doing so by July 2023. ICBs will be able to delegate functions and budgets to place-based partnerships and to provider collaboratives while maintaining overall accountability for NHS resources.

The Explanatory notes to the Bill suggest that local authorities will be equal partners in the new system. The ICB and local authorities in the system must have regard to the integrated care strategy when making decisions.

Place-based partnerships

Place-based partnerships involve local organisations responsible for planning, arranging and delivering health and care services. In many areas these involve shared leadership, joint commissioning and integrated service delivery. Many also have a role in promoting health and wellbeing and tackling health inequalities and work with the local HWB.

NHSEI and LGA interim guidance on place-based partnerships, Thriving places, says existing arrangements that are working well should be built upon. The guidance is intended to help partner organisations in ICSs to collectively define and agree their place-based partnerships, using principles such as 'subsidiarity' and 'form follows function' to:
- define place within the health and care system
- define the purpose and role of place-based partnerships
- establish leadership, governance, decision-making and accountability.

Place-based partnerships are described as the foundations of ICSs. They are seen as playing a 'central role' in planning and improving health and care services as well as working with others to tackle health inequalities and influence the social determinants of health. The guidance identifies several potential models for place-based partnerships, including a three-tiered model of systems, places and neighbourhoods. It is suggested that systems, covering a populations of around one million to three million people includes the whole area's health and care partners in different sectors, which come together to set strategic direction and to develop economies of scale.

People at the Heart of Care: adult social care reform white paper December 2021

This white paper is based on person-centred care and emphasises choice, control, quality, fairness and accessibility and sets out these key objectives:

- people have choice, control and support to live independent lives;

- people can access outstanding quality and tailored care and support;

- people find adult social care fair and accessible.

It restates the commitment to greater collaboration between sectors but does not focus on integration. That is the task of *Health and social care integration: joining up care for people, places and populations*, published in February 2022.

It does, however, emphasise that health, care and housing has to become a coherent system that works together to improve shared outcomes: integrated care partnerships will have a critical role in driving this integration. All local areas will agree a plan embedding housing in broader health and care strategies, including investment in jointly commissioned services.

The King's Fund said[15] that 'the proposed legislation aims to avoid a one-size-fits-all approach and leaves many decisions to local systems and leaders.' This takes into account the difference in geography, demographics and need across the country. It does, however, mean that 'there are significant differences in the size of systems and the arrangements they have put in place, as well as wide variation in the maturity of partnership working across systems.'

Because 'It is not possible to legislate for collaboration and co-ordination of local services', the success of future health and care policy will depend on the leadership, behaviours, relationships and attitudes among the partners involved in local health systems.

During the Covid-19 pandemic, when the reliance on partnerships and collaboration became acute, the existing relationships between directors in public health and colleagues in the local authority and the local area was a factor in their ability to influence to influence and lead the system[16]. In a 2019 report on system leadership, the Kings Fund argued that we need a 'new mindset' that:

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15 https://www.kingsfund.org.uk/publications/health-social-care-white-paper-explained
16 Kings Fund (2021) A Year Like No Others

'has systemic thinking at its core. We now need our leaders, at all levels, to work with what emerges as well as what was planned, to sit with uncertainty and to embrace self-organising principles. We need them to seek out collaborative partnerships and conversations, to ask questions and be curious, and, importantly, to invite others to do the same. They need to embrace complexity, bring a fresh approach to old and familiar problems and be up for self-reflection and experimentation.'

Conclusion

Good local health systems depend on relationships of trust, transparency and cooperation.

Yet the focus of systems thinking is often structures and processes, rather than people and relationships. This is also the case for our public debates around devolution and levelling up, which are all too often pulled towards debating the "correct" structural fix for local government.

As the local elected institution, with a remit for providing a wide range of services and establishing connections between citizens and the state, local authorities are best placed to bring coordination to local health systems. However, chronic issues around funding and capacity hamper the efforts of local authorities to act as leaders.

In England we find that there is enthusiasm among policy makers for approaching local population health through the lens of system thinking, recognising and building on the connectedness between different providers, services, organisations and businesses. But this enthusiasm is not matched by action.

There is a disconnection between institutions, such as local government and the NHS. Meanwhile, there is not as much appetite for taking risks when it comes to changing how services are commissioned or the behaviours that are expected from council staff. This despite the fact that innovation and behaviour change is precisely what is required.

To move forward on this agenda, leaders need to provide the right framework and incentives for staff to innovate. New approaches and collaborations can entail risks that things won't work and we need to create the conditions for trust and collaboration, aligning incentives and performance indicators accordingly so that staff feel safe enough to look around them, taking a system-wide view of the work that they do.

We need to enable a culture that values strong relationships, shared responsibility for outcomes, and an appetite for risk taking and innovation. Local authorities and other public agencies, including NHS trusts, CCGs, health and wellbeing boards, as well as new Integrated Care Partnerships, need to front up to the challenge and provide this system wide leadership.

But system change and behaviour change cannot be done on a shoestring.

Capacity is already stretched in local government and in the NHS. We need to move on from the piecemeal, ad hoc and short-term patchwork of ring-fenced pots that Whitehall makes available to councils for capital spending and provide decent, sustainable funding for local government. Additional responsibilities for long-term strategy and partnership building should not impose greater demand on local authorities without proper support.

Ultimately, devolution and levelling up will only be meaningful if local government is enabled to develop its capacity and given the support it needs to lead locally.

Case Studies

London Borough of Brent

Brent Council worked with the Design Council to develop the support they give to children, young people and their families so that they could avoid the children having to go into care. They wanted to find innovative ways to keep children at-risk of going to care with their families with the aim of eventually reducing the number of children becoming Looked After Children.[17]

Before beginning on this journey, Brent knew that issues such as gang-related activity, domestic abuse, substance misuse and poor mental health were the key drivers behind the need for children to enter the care system. Their own research showed that 31% of new Looked After Children placements were potentially avoidable. These are cases where early intervention could have made a difference to the eventual outcome for these children. The challenge was to identify which interventions would work best and which professionals across a range of services were needed to make these interventions as effective as possible.

The team used a number of tools to help them identify opportunities for intervention that existed in vulnerable children's journeys. They carried out semi-structured interviews with staff and had in-depth conversations with the young people themselves, other customers and professions in other agencies that they work with. They used a 'test-and-learn' approach, similar to the Check-Plan-Do approach outlined above, to make sure that they were on the right track, with young people taking part in workshops as part of this process.

The research process identified a number of problems with the existing support arrangements for children at risk of entering care. Professions spoke of inconsistency in measurement and gaps in certain services and overlap in others. Parents wanted more support in supporting their children through difficult times. The young people spoke about their anxiety over their family's living conditions, their future and how they could survive in their environment in which they lived.

17 https://www.designcouncil.org.uk/resources/case-study/brent-council-keeping-vulnerable-young-people-safely-community

Speaking to service users was not just important for the team to understand the inefficiencies in the existing process but was also helpful in reminding all those involved about why it was so important to get things right; it reminded people about the people at the centre of the system.

The team was still in the prototyping phase when the case study was written but they already had interesting ideas that they wanted to implement and test. These include:

- A dedicated early response team that is mobilised quickly to support families in crisis

- A family hub to bring together professionals, community groups and parents to facilitate connections to provide support for children and young people. These include services to support confident parenting, the building of self-esteem and resilience and English language skills.

- An out of hours service to provide support for young people when they need it the most.
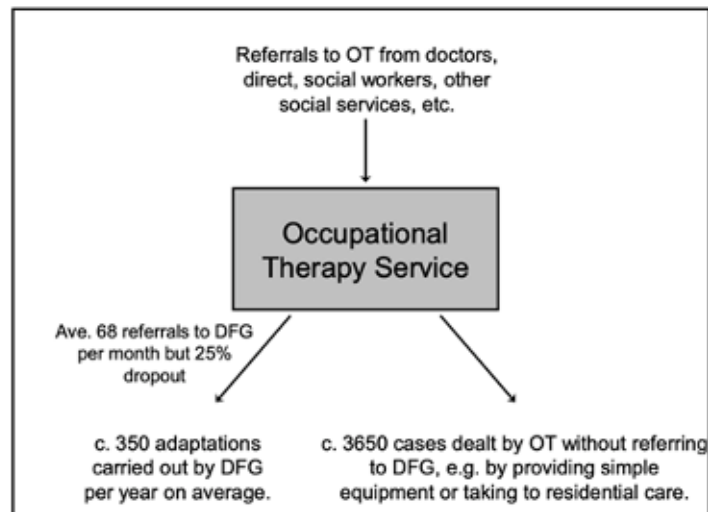
Neath Port Talbot County Borough Council

Neath Port Talbot[18] wanted to carry out a systems thinking review of their Disabled Facilities Grant (DFG) service. Demand for the service had increased and a decision had to be made about whether to increased capacity. Therefore, the review aimed to design a new system capable of being able to adapt and respond to this new demand.

Despite significant investment (over £20.5 million was spent on home adaptations to aid disabled residents), demand was increasing and Neath Port Talbot was judged by a national indicator to be performing badly; it was ranked 21st out of 22 authorities on the average time it took to deliver adaptations. Interestingly, customer satisfaction questionnaires showed that 99% of clients were satisfied with their DFG.

The council put together a five-strong team to review the service using systems thinking in November 2008. The team used the 'Check Plan Do' approach to systems thinking as outlined below. The team began with 'check phase' by defining the purpose of the DFG service. After spending considerable time listening to customers and finding out what mattered to them, they defined the purpose (from the customers' point of view) as: "To provide the right help for me, when I need it, to maximise my independence".

Next, the team continued to study the demand. They found that although the DFG service was overwhelmed, only a fraction of requests for support were referred to the service due to the long lead times. Of those that were referred, 25% dropped out due to the long wait for adaptations.

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18 Zokaei,K. Elias, S. O'Donovan, B. Samuel,D. Evans, B. and Goodfellow, J. (2010) "Lean and Systems Thinking in the Public Sector in Wales" Wales Audit Office. Accessed online: https://www.wao.gov.uk/sites/default/files/ Lean_and_Systems_Thinking_in_the_public_sector_English_2010_14.pdf

Referrals to OT from doctors, direct, social workers, other social services, etc.

Occupational Therapy Service

Ave. 68 referrals to DFG per month but 25% dropout

c. 350 adaptations carried out by DFG per year on average.

c. 3650 cases dealt by OT without referring to DFG, e.g. by providing simple equipment or taking to residential care.

(Figure shows demand over 3 years into the Disabled Facilities Grant Service at Neath Port Talbot County Borough Council)

Further enquiry showed that of the 750 people who entered residential care over a five year period, 244 had been previously identified by occupational therapy for a DFG. Eighty-five out of the 750 received DFG and later went into care at an average age of 84 years. One hundred and fifty-nine did not receive a DFG due to the long waiting time and were admitted to care at the average age of 80 years old. Therefore, the evidence showed a strong correlation between the DFG being granted and the age at which people were no longer able to live independently. As well as the huge impact on the individuals concerned, DFG delays also cost the public sector money in the form of additional residential care costs.

Next, the review team examined how far the DFG service was meeting its purpose. The service's functionality was measured by looking at the end-to-end time measure of completing the work. It was found that the average time it took to complete DFG work was 675 days (435 days waiting and 240 days installation time).

The team went onto the map the service flow. This is an essential step in order to ensure that all steps in the process are effective. They found that the DFG process involved 291 steps, of which only 20 were of value to the customer, based on the purpose of the service. DFG expert staff only got involved after the case has been through several hand-offs and front-line staff have little authority or expertise to deal with cases themselves.

After completing the 'check' phase, the review team moved onto the 'plan' phase of their investigations. This involved experimenting with different systems in order to find one that would work better in achieving the purpose from the customer's point of view.

One of the key aims of the design was to eliminate non-value adding steps as far as possible from the process. This was achieved by bringing expert staff to the front line which meant that there were able to engage with clients as the first point of contact. This meant that customers were able to meet with the decision-makers early in the process, that installations were arranged at a time that suits them and that they were not passed around from staff to staff.

As well as improvements in the customer experience, there were also benefits to the staff involved in DFGs, some of whom said that this piece of work was the most important that they had been involved with.

Other benefits of the new process was that the same surveyor took on the whole build process, from design to certification. The DFG team also started collecting data based on meaningful measures to support continuous improvement. The redesign has lead to a reduction in lead-in times and has saved the service money.

DFG measure	Old system	Redesigned system*	Comments
Average end to end time	675 days	64 days	675 made up of 435 wait and 240 install
Flow steps (end-to-end)	291 steps	34 steps	Every step from first point of contact to completion of works
Preventable demand	71%	40%	See above
Costs of delivery (average per grant)	£499	£319	Staffing activity costs (36% improvement)
Cost of physical works (average per case)	£7000	£6300	Procurement savings and reduction in re-work
DFG dropouts	33% of cases	Nil	Early intervention prevents dropouts

*The results are based on a sample of 39 completed cases. The redesign of the service is still evolving and continuous improvement may lead to further improvements.

While the case study was written while the 'do' phase of the 'Check Plan Do' approach was just beginning, it is clear to see that a systems thinking review of the DFG service at Port Neath Talbot was a success even at an early stage.

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