Learnings from the HSJ Provider Summit 2019
Interactive Discussion Groups

Session Theme: **Collaborating across the system to integrate care pathways**

Session Leader: **Nick Kennell, Gate One, Health & Social Care Practice Lead**

Key Questions Posed

1. What do we need **beyond structural changes** (e.g. system-wide control totals) for collaboration to work? Are we concentrating on the right structures to change?
2. How do we continue to foster **provider-to-provider collaboration** across STP/ICS boundaries and what is needed for that to thrive?
3. How do we get more consistent **cultures and ways of working** across organisations?

Outcomes and Learnings

Forming the 'new, old corridors of power'

The message was clear: as new integrated pathways become embedded across regions, the 'new, old corridors of power' are forming again. In this context the 'corridors of power' are the decision-making relationships that existing at a health-economy level. They are 'new' as they are responding to:

- New policy (Long-Term Plan) and competition landscape
- New ways of driving change – 'less money, more politics as the levers of change'
- New risk profiles to galvanise pathway change and build system-wide momentum

But they are also old – perhaps even ancient – as they are rebuilding those that had existed before, as SHAs and RHAs (even AHAs).

What this means personally

Participants agreed that for system leaders – commissioners and providers – new collaboration and models required them to change behaviours, including:

- Spending significantly more **time outside of their organisations**, with some noting a trembling of meetings in diaries – 'we are seeing a significant up-tick in time and energy required from managers to ensure that less time and resource is required from patients'
- A need to purposefully **change 'hats'** as they walk between rooms – 'one meeting I need to be thinking about my organisation, the next it's supporting on system-wide benefits outside of my remit'
- Maximising **personal authority and relationships** to drive integrated change and trust – 'managers and system leaders are having to use their relationships to drive change, learning from the deep clinical relationships that sit across the systems'

Personal conclusions were that this was a new age for diplomacy-led leadership, requiring tact and nuance, that have not always been the historic mainstays of high pressured operational decision-making and leadership in the NHS.

What this means collectively

1. ***Building local accountability***:
   - Holding everyone true to required behaviours: there was agreement around the need to effective lead across systems by demonstrating "constitution-aligned"

behaviours. There are examples of where this is developing, such as the STP-wide capital prioritisation that has started to encourage more collective thinking about VfM across the system.
- This comes from building shared goals: Setting a vision, building out objectives and then working towards an outcomes framework for an ICS were critical. Equally important is collectively working to address any unintended consequences of decisions – such as the impact on social care of increasing discharge rates.
- Collectively owning performance: 'Can and should a whole ICS support a failing organisation? Should it? Is performance management too far?'. Response was varied, but there was consensus for a pull in this direction.

2. ***Addressing the 'myths'***:
   - Integration won't save money: we need to be realistic around the costs to get integration right – it will cost the same, integration just moves where that cost is felt
   - The new regionalism isn't just about the new regional organisations: functional geography based around population movements is as important as the new regional forms.
   - It is too simplistic to bemoan 'too many organisations' in the NHS: integrated care does not automatically mean integrated organisations. We need to be mindful around how to ensure mental health and community care lead decision-making. Mergers run the risk of making mental health and community care poorer cousins whose remits get subsumed.
3. ***Building central trust:***
   - The elephant in the room is regulation: collaboration is improving, but regulatory bias towards organisation-based thinking remains. We will soon need to get to an answer for how we regulate on a regional level.
   - We can learn from the education sector: Some saw parallels between CQC's journey and that of Ofsted– is there the potential to use greater self-assessment to promote regulatory trust?
   - Communicating change and accountability: as important as the change journey is within each region, better explaining the 'what, who and how's' at a system-level to the centre was going a key learning. For example, on major programmes of change to central assurers or to MPs.

Conclusion

Integration is far from straight-forward, there are multiple elements that can work against it or undermine it, from a structural, behavioural, financial and regulatory perspectives. That said, the world is moving and health leaders are taking a positive role in making that happen.

Further information:

Gate One is a digital and business transformation consultancy. We help health and care organisations answer the questions that matter.

Nick Kennell leads our health team at Gate One. He is passionate about working on the things that matter most in delivering improved, sustainable care to patients. He has worked across the health sector to help rebalance programmes in favour of empowering teams to deliver lasting benefit and improved quality.

Email: nick.kennell@gateone.co.uk

Telephone: 0771 890 7611