**There is broad support for place-based working as the right level to tackle health inequalities and drive integration. But an HFMA roundtable, supported by Newton, heard that systems also face major challenges in realising their place-based ambitions**

# THE PLACE TO BE

HFMA ROUND TABLE

There is huge support for places – the natural geographic area within an integrated care system in which people access care and support – as the right level to integrate and transform health and healthcare services. But structures and working practices are evolving. And there are obstacles to be overcome, including moving away from an organisational focus, while facing system pressures in urgent and emergency care and elective recovery.

These were some of the key messages from an HFMA roundtable held this summer, supported by Newton, to explore how place-level working was developing in practice.

Emma Sayner, deputy director of finance at Humber and North Yorkshire Integrated Care Board, said her system had been discussing the value of place as it moved from six clinical commissioning groups to a single integrated care board (ICB). The focus in the past year has been on delivering stability, on creating the new organisation and dealing with the significant financial and operational challenges.

The operating model in the Humber and North Yorkshire includes six places, four provider collaboratives and a variety of provider organisations. 'What the discussions have done is to reaffirm the passion that place is the right level to deliver real change and improvements to outcomes,' she said. 'The ICB is in the process of delivering a "do once" approach across the system, which is about making the systems and processes work as efficiently as possible, freeing up the teams across all functions to identify the high-impact opportunities for improvement and hone down on what difference local decision-making can contribute.

'This will allow greater understanding of the needs of our population, almost at street level in some cases, and then [we can] think about how we meet those needs.'

Working at place meant building on collaboration with local authorities and 'shaping the out-of-hospital environment', she said, and it was the best level to tackle issues such as health inequalities.

Ms Sayner warned against creating 'mini-organisations' that compete with each other. But places would need to have the tools and right skills to make a real difference to local communities.

'The wider provider landscape, across all sectors, is still very fragmented and the ability to gain mutual accountability and use workforce and resources more flexibly rather than focusing on organisational targets – both financial and operationally – is an ongoing issue,' she said.

'Getting a wider view of population health, and targeting resources accordingly, is very much the ambition, but still work in progress.'

Spencer Prosser gave a provider perspective. He is chief finance officer at Lewisham and Greenwich NHS Trust and part of the South East London integrated care system.

## Different views

System working could be viewed differently, he said, depending on whether you looked at it operationally or financially. Operationally, place was working well. There were lots of conversations about issues such as discharge and integration of mental health support in hospitals and community services.

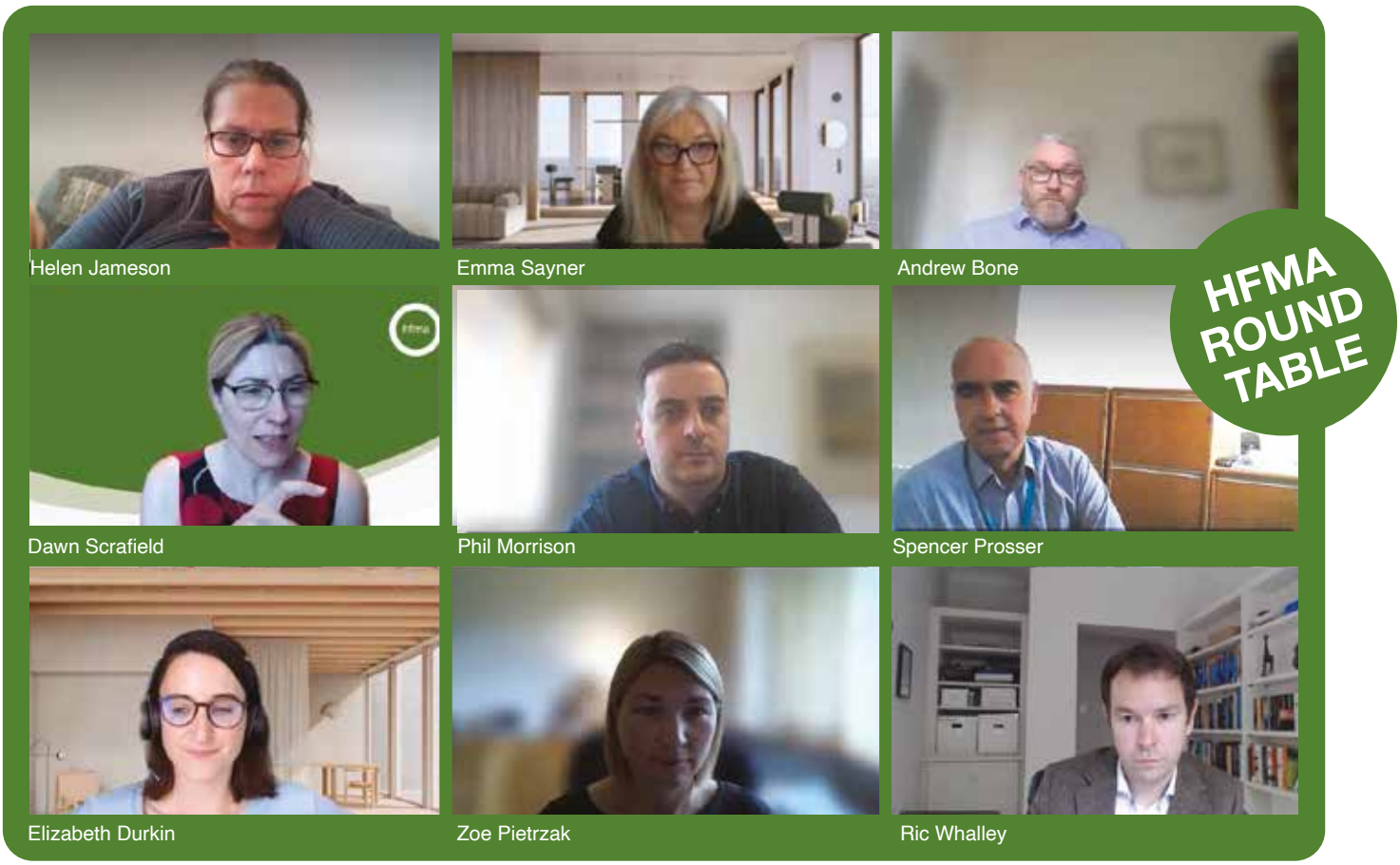
'But financially, it is completely irrelevant,' he said. 'All of our conversations and the vast majority of our numbers are done at scale at the ICB level.'

Providers were almost inevitably 'fixated on elective waits'. 'Place folk find it really difficult to get any airtime into anybody's diary because the numbers they are talking about in pound signs are much, much smaller than most of the things that we deal with in our organisation.'

As such, place-based working could at best be described as 'embryonic' or a 'work-in-progress', added Mr Prosser.

Ric Whalley, a partner with Newton, said the real opportunities provided by place-based working were in doing things differently. In particular, this should involve looking at end-

SHUTTERSTOCK




to-end pathways and tackling overall demand, rather than just the demand for a specific part of the pathway. And he argued that these opportunities would actually help providers to meet their financial and recovery goals. It was not a case of one or the other.

'We've seen examples where, if you design the right model around a neighbourhood team, they can lower long-term need for social care by 25%,' he said. 'That can be pretty material to a provider's balance sheet.

'Similarly, we've had examples in Northamptonshire of a 9% reduction in attendances and admissions. Again, that starts being really material for a provider.'

Mr Whalley said systems and places needed to start linking the opportunities that exist for improving outcomes to some of the wider operational pressures.

'There are opportunities where doing the right thing for those pathways can deliver the right thing operationally, as well as actually having quite a sizeable financial impact.'

Zoe Pietrzak, regional director of finance for the NHS England Eastern region, was previously chief finance officer at Great Yarmouth and Waveney Clinical Commissioning Group – now part of the Norfolk and Waveney Integrated Care Board. She said place-based working was essential to meet the needs of very specific populations.

'The demographics in Great Yarmouth and Waveney were so very different from those of the rest of the system,' she said. Planning to meet the needs of distinct populations had to be done at place level, building on the passion of place-level staff to deliver for their populations. How else could systems meet the needs of very different areas within their overall populations?

But she agreed that one of the challenges was getting providers engaged at place level and the whole out-of-hospital agenda. There was a danger that people were in 'immediate action' mode and responding to the clear national focus on elective recovery. But developing out-of-hospital services was part of the solution to reduce elective waiting lists.

Dawn Scrafield, chief finance officer for Mid and South Essex NHS Foundation Trust and the roundtable's chair, agreed that providers need to get involved with place-based working. But she worried about a tendency for discussions to end up focusing on how to contract for services differently. 'I don't think that is the aim or the ethos of what we are trying to achieve,' she said.

## Participants

- Andrew Bone, NHS Borders
- Liz Durkin, NHS England
- Helen Jameson, South West London Integrated Care Board
- Phil Morrison, Newton
- Zoe Pietrzak, Eastern region, NHS England
- Spencer Prosser, Lewisham and Greenwich NHS Trust
- Emma Sayner,Humber and North Yorkshire Integrated Care Board
- Dawn Scrafield (chair), Mid and South Essex NHS Foundation Trust
- Ric Whalley, Newton

## Change of focus

She added that language was important. Instead of the typical focus on unit costs – and mostly provider unit costs – there needed to be a move to thinking about resource consumption. 'Places need to understand how much their population is consuming from a resource perspective and translate that into things like impact on health inequality, comparing resource use with actual outcomes.'

Costing teams, she suggested, needed to start supporting this agenda – looking at pathway costs and resource consumption by different parts of the population and the outcomes this was delivering. A costing hub in the local Essex system is starting to do this work.

'Hopefully then you can engage in a different conversation with the result of a less acute

medical model and more of a preventative community-based way of caring for the population,' she said.

There was agreement about the need to develop the right kind of business intelligence to support place-based working, starting with an understanding of the resources being consumed at place-level and by different groups within the local area.

Elizabeth Durkin, financial framework lead for NHS England, stressed the importance of moving beyond the view of resource consumption at the provider level. 'We need a stronger understanding of the totality of system resource consumption,' she said.

A provider may undertake a procedure in a really efficient way. But this might still be in the context of above-average spending or poorer outcomes for the population in that specialty or treatment area. From a population perspective, the money might be better spent in care that avoids the patient needing the procedure in the first place. But you wouldn't see this by just looking at the provider numbers.

'We have strong and evolving tools around patient-level cost data, but how do we ensure we have replicable levels of detail more broadly than just hospital-based care?' Ms Durkin added. 'That will help us to really target in on the areas of opportunity and improvement.'

She highlighted the place-based allocation tool provided by NHS England, which takes the ICB weighted capitation allocation methodology and cascades it down to places. But she said this should be integrated with a broader view of resource consumption.

## Role of finance

Finance teams will have a big part to play in the delivery of information to support place-based working, particularly in identifying the resources consumed by different parts of the population and linking this to outcome data.

Many teams are already working to their maximum, and ICB teams have faced a particularly busy workload in the transition to system working. But there was agreement that time had to be found to deliver these new information flows, creating room by stopping current processes that add little value.

Ms Sayner stressed that granular-level data intelligence was important to support places to identify need and to be able to respond.

'There is not necessarily a gap; I think the data is there. But how we use it – and have a single point to make it easily accessible – is part of system development,' she said.

The national Model Health System data was a good example of the data available. 'But I'm not sure it is systematically used yet as it might be to drive increased efficiency from both a technical and allocative perspective.'

**"Local authorities plan much more on the basis of population change and what actions can be taken to prevent that prediction. The NHS doesn't plan its use of resources in that way at all"**

**Dawn Scrafield, Mid and South Essex NHSFT**

Phil Morrison, a business manager at Newton, also wondered if the NHS was too narrowly focused on improvements that deliver cash savings. 'We are still trapped in a 12-month performance cycle, where we predict attendances and admissions year-to-year, but we forget about demographics,' he said. So 'bending the curve' and keeping performance or activity flat, while demographics are going up, can represent a significant improvement.

'There is no common understanding of what demand will look like in one or two years if we do nothing,' he said. 'But getting everyone onto that common ground can really help to focus attention and underline that it isn't all about getting cash out this year.'

Ms Scrafield reinforced this point. 'We know our local authority partners plan much more on the basis of population change in the future and what actions can be taken to prevent that prediction,' she said. 'But the NHS doesn't plan its use of resources in that way at all.'

Scotland has been operating in a more integrated delivery model for some years, with health boards and local authorities coming together in integration joint boards.

Andrew Bone, director of finance of NHS Borders, said the challenges of integrating services and finding the right level to plan services were similar to the rest of the UK. But focusing on place really supported the integration and joint working agenda.

'A lot of our dialogue for all of our planning is based around place because it is based around communities,' he said.

The key was looking for the similarities and differences between separate groups of people and then planning for them specifically. When there was a place focus, conversations often turned to issues such as transport networks and housing that all contribute to how and why people access healthcare. 'And that takes us into conversations with other public sector partners,' he added.

In the Borders, which is characterised by lots of small villages and towns, it is not uncommon to find places that all have their own police station, fire station, health centre and council buildings – many of which may be empty or poorly used for part of the week.

'Suddenly you start looking at opportunities to do something differently and start looking at transport networks,' he said. 'We are now talking about having things like net carbon reduction programmes that would extend across all our public sector bodies and have one programme we would all participate in.'

While this may not be about delivering care to patients in a different way, Mr Bone said, it was an opportunity that had only arisen because of discussions at a place level. Talks are under way about collectively contracting with a single organisation to manage buildings across all public services.

HFMA ROUND TABLE

There was real potential with social work and care at home, he said, where it was possible for a single person to visit a house and deliver a range of functions rather than everything being delivered separately.

Helen Jameson, chief finance officer for South West London Integrated Care Board, said one of the challenges was balancing economies of scale – doing things at a system level – and supporting local approaches. The Covid pandemic encouraged people to innovate at a local level, delivering some amazing improvements for local populations.

'This has also led to greater differentiation,' she said. 'So we now have lots of little contracts that have grown for all the right reasons. The challenge is getting the balance right so we have localism, but we also get economy of scale. It is exciting what we might be able to achieve, but at the moment we have almost gone too far – enabled by Covid. How do we rebalance the position without stifling innovation?'

Mr Prosser wondered if providers were set up properly to support a place-based focus. 'We are often looking to standardise pathways across the organisation, irrespective of where parts of the organisation are situated – looking to reduce unit costs and standardise production, rather than necessarily being tapped into the whole locality wellbeing agenda,' he said.

But at the same time, it didn't make sense to have the trust's chief operating officer attending three separate place meetings to talk

about the same thing. Structures and processes weren't currently right to support place-based working, said Mr Prosser, but he made a plea for any new approach to be kept simple.

Newton's Mr Whalley agreed with the plea for simplicity and added that standardising pathways across organisations often made sense, once you understand where the priorities are and have decided that this is the right treatment option for a patient. But the greatest efficiency could often be achieved by getting the decision about the placement right in the first instance.

'In one place, we looked at the urgent care pathway and were able to increase the throughput by 80% to 90%, avoiding patients being admitted into an acute,' he said. 'That is a huge difference, but it was not about improving efficiency of the hospital services, it was about improving the understanding of the decision-making and ensuring the community option was used consistently.' The key, he suggested, was recognising where the value was going to come from.

## Pooled budgets

Ms Pietrzak said pooled budgets offered one way to stop finance being a barrier, so that funds to support place-based joint working were already identified, rather than having to make separate cases all the time.

She also stressed the importance of whole organisations understanding the value of integrating services. 'We can talk about it at board level, but if that's not filtering down through all levels of the organisation, it's not going to work,' she said. 'We need ownership and autonomy at all levels of an organisation to enable integrated conversations to take place.'

There was a recognition that place-based working was in its infancy. However, attendees pointed out the importance of improving the maturity of arrangements. Many of the key objectives for systems and ICBs could only be delivered by taking a place-based approach.

For example, addressing health inequalities and the wider determinants of health could only realistically be taken forward with an understanding of local populations and place-specific challenges that need to be overcome.

Mr Bone believed that getting the framework right for place-based working was important. This meant 'embedding a place-based approach in strategic documentation'. 'It needs to be as visible as possible and state that we are going to work in this space with this intention,' he said.

Being clear about governance arrangements was also important. 'We've had problems with things like business cases when you are working with multiple agencies and you need to take it to lots of different meetings to be approved and the timings don't work out,' he said. 'So, one of the things we've done is to create a joint executive team meeting where we have developed new governance that enables us to operate in that space.'

There are other challenges to working in collaboration – establishing a single format for reports so reports don't need to be rewritten multiple times for different agencies and working out ways to agree financial contributions to schemes when working with lots of different sized bodies.

There was some discussion about realising the benefits for place-based initiatives. Ms Scrafield said one of the positives of the response to the pandemic in terms of the vaccination programme was how quickly results were achieved in targeting hard-to-reach communities. 'The outcomes we achieved [by working at place-level] were seen very quickly, but we don't often have that with outcomes or inequalities work, where it is often a much longer burn.'

Ms Jameson added that in the current context, creating the capacity for large-scale change was challenging. 'As we continue to try to evolve at place, it is much more difficult while we are not in a steady state,' she said. 'There are real financial constraints across all sectors, our populations are facing a cost-of-living crisis and the industrial action is taking up resources, effort and headspace - making it more difficult to deliver change.

'This may feel overwhelming, so it's important to set ourselves milestones along the journey so we can understand and celebrate our progress rather than focusing on the end point, which is probably too far away,' she said.

'Intermediate outcomes along the way are really important,' agreed Mr Whalley. 'A lot of topics in this space are so big that if we look at the whole thing, then it is too much to digest.'

He highlighted a system looking to introduce a programme around prevention. It has identified the elderly as one cohort where the programme could have an impact in a relatively short space of time.

'They have done work to predict the people who are going to escalate within a three-month period – and you can get quite accurate with this now using machine learning, predicting 70% of admissions. That enables measurable, preventative activity to be targeted and delivered,' he said. 'That then gives you the space to start extending the cohorts targeted.

'It won't be the same area for everyone, but if you can break it down to the bits that can have a big enough impact to build confidence, and build that culture around working together in a different way around a shared problem, that can be really powerful,' he said.

It was agreed that setting interim goals could be important for a lot of the work initiated at place level to celebrate successes and prevent programmes being cancelled before they have had a chance to deliver.

Participants agreed that one size does not fit all when it comes to how places should be set up. But Ms Pietrzak said places could still learn from each other. 'You might not find a similar place in the same region, but you might find one somewhere across the country.' She suggested that there should be a mechanism to share best practice about what was working in different places.

Ms Sayner added one final plea – for everyone working within systems and at place level to be able to see issues from their partner stakeholders' perspectives.

'It is not just emergency care, or elective care or social care. We all need to be able to understand each other's challenges, because only then can we come together to think about some of the potentially radical solutions.'

Everyone tended to be so 'hunkered down on trying to deliver in their own world', she said, that it was difficult to have the headspace to do the right things differently.

## Summary

There was huge support for working at place-level. All attendees agreed this was the right level to take a pathway focus and to integrate services with other public and voluntary sector providers. They also highlighted a lot of obstacles to making progress, including a preoccupation with elective recovery, the challenging financial context and the need to cut system running costs. Yet place-based working was seen as a solution to some of these issues – and systems had to find ways to make progress.

• *Newton has worked with NHS Providers to develop a* ***practical toolkit*** *to support the design and delivery of integrated care at a local level.*