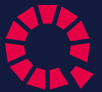
In partnership



Improving health and care at scale

Learning from the experience of systems

November 2023

Prof Sir Chris Ham

About us

NHS Confederation
The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities. For more information visit www.nhsconfed.org

The Health Foundation
The Health Foundation is an independent charitable organisation working to build a healthier UK. Everyone has a stake and a part to play in improving our health. By working together, we can build a healthier society. For more information visit www.health.org.uk

Q
Q is a community of thousands of people across the UK and Ireland, collaborating to improve the safety and quality of health and care. Q is delivered by the Health Foundation and supported by partners across the UK and Ireland. For more information visit q.health.org.uk

We are working in partnership to support local health and care systems to learn and improve. Find out more on page 3.

In partnership

Learning and improving across systems

The Health Foundation, NHS Confederation and the Q community are working in partnership to support local health and care systems to learn and improve.

We will work with health and care systems to boost their capability to learn and improve collaboratively through a programme of support:

- Peer spaces to learn with and from each other, connecting to local improvement ideas and expertise.
- Insight and innovation projects on specific complex issues, testing and learning together.
- Practical resources, materials and connections to support implementation in practice.
- Publications, podcasts and events to share learning and support implementation in practice.

Together, through this programme of support we aim to work with systems to:

- develop learning and improvement approaches needed to meet system goals
- galvanise local improvement ideas and expertise, helping leaders connect from the board to the 'frontline' of delivering change
- pool evidence and experience to understand and make progress on priority topics
- share and scale what we're learning together.

To find out more, visit
www.nhsconfed.org/learning-improving-systems

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Foreword

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Not only the success of the National Health Service but the capacity to improve the health outcomes of our population rests to a significant degree on the success of collaborative working, whether at the level of integrated care systems, places, neighbourhoods or teams.

Leaders are continuously looking to improve the services they offer and there are new opportunities with the development of NHS IMPACT, a single, shared improvement approach.

The majority of improvement efforts have focused on organisations and the services they provide. Understanding what leading improvement and implementing the NHS IMPACT approach means at system level (ie, across local health and social care organisations' boundaries) is at an earlier stage. What are the opportunities and challenges of thinking of improvement through the lens of system working? This is the question explored by Chris Ham in this paper, jointly commissioned by the NHS Confederation, the Health Foundation and the Q community. It is a question he answers in part through a wealth of examples of how systems are already using their mandate to drive improvement in the very challenging circumstances facing health and care services today.

There is no lack of ambition and, as shown in this report, many are already on this journey. The high level of engagement in this research illustrates the hunger for more time to reflect on what improvement means in practice and to develop approaches that help answer the complex questions facing leaders: How do you keep a focus on long-term system goals while under pressure to fix immediate challenges? How do we assign responsibility and build shared ownership for improvement? How can we make it easier to scale learning and innovation between teams and organisations? How can we shift organisation and personal relationships and skills to enable system collaboration?

> “This report celebrates stories of improvement practice already happening and what is possible, grounded in leaders’ own varied experience.”

In finding a way through these and other questions, there is much that people who have a mandate to improve their local health and care systems can build on. This report celebrates stories of improvement practice already happening and what is possible, grounded in leaders’ own varied experience. The case studies bring home the long histories and complex institutional and personal relationships that are the backdrop to systems orchestrating change. The report takes early steps in ‘lifting the lid’ on what works and how we might learn lessons from this practice, with key themes drawn out at the start and end. Given the diverse, interconnected and dynamic challenges systems face, it acknowledges that this will continue to evolve.

The question this report poses is where we go from here. We must learn from evidence and experience, but we cannot ‘copy and paste’ solutions. Leaders need creative spaces where they can unpick what’s being learned and translate lessons between different local areas. As trusted member organisations, our role is to help facilitate this peer learning - to create productive space, spot patterns and surface insights, in ways that are always collaborative and respect the uniqueness of each place.

Standing alongside and learning with leaders, we can help distil and amplify what is needed for systems to self-improve and advocate for protected space and resources to progress this work. Our networks can connect leaders with the thousands of people with improvement expertise, without whom system aspirations and strategies struggle to move to implementation with scale and sustainability.

Alongside the publication of this report, the Health Foundation, Q community and NHS Confederation are launching a joint learning and improvement offer to support ongoing shared learning across the UK between local health systems. The offer will build on existing networks to create well-facilitated peer learning spaces where leaders can explore their 'wicked problems' and start to co-develop solutions. The focus will be on helping leaders with their core work of continually improving how they deliver. As organisations with reach at all levels, we will strengthen the link between local experience and national policy development so that it increasingly creates the contexts that systems need to thrive. The offer will be open to all systems, regardless of where they are on their journey, aiming to unleash the potential of local leaders and the improvement ideas and expertise that exists in every system. You can read more on page 3.

Epigraphs

> "We know that high-performing organisations and systems combine high levels of autonomy with high levels of accountability. ICS leaders themselves increasingly want to create a self-improving system – empowered and strong enough to set strategy, agree plans and trajectories and to mobilise the collective time, talent and resource of system partners to realise them...I urge ministers, NHS England and ICSs to confirm the principles of subsidiarity, collaboration and flexibility that were set out when ICSs were being established and explicitly commit to supporting ICSs to become 'self-improving systems."[1]

> "Our overarching ambition is to enable the creation of an NHS in which every organisation, including NHS England, has the leadership with the leadership behaviours, the capability and the capacity, to enable our staff to solve the problems that matter to them, their patients and their populations. Working with their partners to deliver better life chances and better outcomes for those patients."[2]

> “Countless initiatives languish because planners believe that the existence of a new, better practice is, in and of itself, sufficient to guarantee its adoption. They rely on existing channels (e.g. government mandates, guidelines or publications) to spread their ideas. Successful large-scale improvement programmes instead select a structured process for spreading changes through participating organisations. The core task...is to build a mechanism for distributed learning among participants (an organic ‘learning network’) that generates meaningful exchange on a daily basis.”[3]

> “People own what they help create.
> Real change happens in real work.
> Those who do the work, do the change.”[4]

Key points

- NHS England has outlined plans to develop an improvement approach known as NHS IMPACT to support continuous improvement. There are also ambitions for integrated care systems (ICSs) to become 'self-improving systems'. This report reviews the experience of a number of ICSs identified as being at the forefront of this work, focusing on the approaches they have taken and the results achieved.

- Work to improve health and care is underway in neighbourhoods, places and systems with provider collaboratives and health innovation networks (previously known as academic health science networks) also involved. System leaders describe themselves as convenors and enablers of improvement in the system, by the system and of the system. They have been resourceful in 'going with the grain' of existing improvement methods, creating improvement and learning communities of experienced staff, and sharing expertise with organisations and services that may lack capabilities.

- ICSs emphasised that their work is at an early stage of development but each gave examples of how they are beginning to make a difference for the populations they serve. These examples encompass improvements in population health and the delivery of care, including a focus on both national priorities like elective care and local priorities identified by NHS organisations, local authorities and other partners. Data has been used to understand need and demand for care and to develop actionable insights for improvement.

- There have been challenges in releasing staff to work on improvement because of operational pressures, industrial action and staff shortages. There are also tensions about the respective roles of NHS trusts, provider collaboratives and integrated care boards in leading improvement. System leaders expressed concerns that the legacy of top-down performance management in the NHS might create barriers to realising the ambitions behind NHS IMPACT.

- No country in the world has put in place a learning and continuously improving system on the scale of England. There needs to be realism about the time it will take to do so and constancy of purpose on the part of national leaders. The NHS should adopt a 'high trust, low bureaucracy' philosophy in leading transformational changes and value agile leadership and effective partnership with local authorities, voluntary and community sector organisations and others. Leaders should recognise that spreading innovations requires adaptation and skills in taking something that works in one context and making it work in another.

- The NHS Confederation and the Health Foundation should support learning between systems in real time, the development of collaboration and leadership skills, and identify worthwhile innovations in improvement practice. The National Improvement Board should use the findings of this report in shaping its strategy and should ensure that expertise in ICSs and other partners is used. Evidence about work on improvement should be easily accessible, drawing on the resources of the Health Foundation and others.

History and context

The recent history of the NHS in England is littered with examples of policies to improve patient safety and the quality of care. Beginning with 'A first class service' in the late 1990s, the next decade saw a wide range of quality improvement initiatives, described in an independent review as 'a bewildering and overwhelming profusion of government-imposed policies and programmes'.[5]

Policy activism continued unabated in the years that followed, from Lord Darzi's report High Quality Care For All,[6] through the response to the Francis inquiry into Mid Staffordshire NHS Foundation Trust,[7] the Ockenden report into Shrewsbury and Telford Hospital NHS Trust,[8] and much more. The case for a national quality programme and an integrated quality strategy has been made[5] but not heeded. Lack of constancy of purpose helps explain the limited impact of national initiatives.

More promising has been growing interest within the NHS in the use of quality improvement methods. The NHS Modernisation Agency (see box 1) played a major part in this work between 2001 and 2005 in programmes to improve patients' access to care and standards in cancer services and accident and emergency departments.[9] This work evolved in the context of the then Labour government's commitment to increase NHS spending and reform service delivery.

At this time and subsequently, many NHS organisations set up their own quality improvement programmes, often in partnership with internationally renowned healthcare systems and organisations such as the Virginia Mason Medical Centre (VMMC) and the Institute for Healthcare Improvement (IHI). This included improvement programmes across a region[10] and those involving a number of trusts in different regions.[11] Regional agencies like the Advancing Quality Alliance (AQUA) emerged to support this work.

Box 1: The NHS Modernisation Agency

The NHS Modernisation Agency grew out of the National Patients' Access Team, which had achieved some success in supporting the NHS to reduce waiting times, and a number of other improvement initiatives.[12] The agency's work focused initially on the implementation of the booked appointments system, the cancer services collaborative, and a programme to reduce waiting times in accident and emergency (A&E) departments. It also contributed to the development of skills in quality improvement and service redesign, as in work to improve access in A&E departments. From small beginnings, it expanded to take on many more improvement programmes and by 2003 employed 800 staff.

The rapid growth of the agency was testament to its success, but also created problems. These included staff with improvement expertise being taken away from work in NHS organisations that were directly providing patient care, to work on national programmes set up to support and advise these organisations on how to achieve improvements. NHS organisations found themselves receiving support from more than one of the national programmes being run by the agency, often with weak co-ordination between them. These and other factors led to a decision to wind down the agency's work. Greater emphasis was placed on improvement programmes being led at regional and local levels, with national expertise concentrated in a smaller national body: the NHS Institute for Innovation and Improvement.

Quality improvement encompasses a range of activities, focused on ‘designing and redesigning work processes and systems that deliver healthcare with better outcomes and lower costs, wherever this can be achieved. This ranges from redesigning how teams deliver care in the clinical microsystems that make up healthcare organisations, to large-scale reconfigurations of specialist services such as stroke care and cancer care. It includes design of training, budgeting processes and information systems and requires leadership and cultures that both understand and value quality improvement.’.[13]

Quality improvement is closely related to changes that are sometimes described as transformational because they involve fundamental shifts in how healthcare and other services are organised and delivered. A recent report described four examples and distilled the factors that both facilitated and inhibited change.[14] The authors showed how transformations can arise from different sources and require persistence in the face of adversity, scepticism, and the messy processes involved.

A recent briefing from the Health Foundation also sets out evidence for why sustainable change for the NHS and other care sectors can only be achieved through improvement approaches.

Communities as well as staff play a vital role in transformational changes, as illustrated by the experience of Wigan where local government leaders and their partners embarked on radical reform of service delivery in response to austerity policies pursued by central government.[15] The Wigan Deal, as it became known, sought to build on the strengths and assets of communities to improve outcomes. This included the council investing more in voluntary and community sector organisations, which were able to step in to fill gaps created by cuts in public services.

Underpinning the Wigan Deal was a change in culture entailing council staff being trained to discuss with citizens what their needs were and how public services could be changed to meet

these needs. An anthropologist advised the council on these issues. Donna Hall, chief executive of Wigan Council for much of this time, explained the value of political leadership and having an executive team fully committed to leading change. Giving staff and the community permission to take risks and innovate was another key factor.

The Health Foundation, Royal Colleges and others helped build capacity and learning about improvement work through training, research and the development of networks like the Q community. The final section of this report signposts key resources relevant to the needs of local systems that this report identifies.

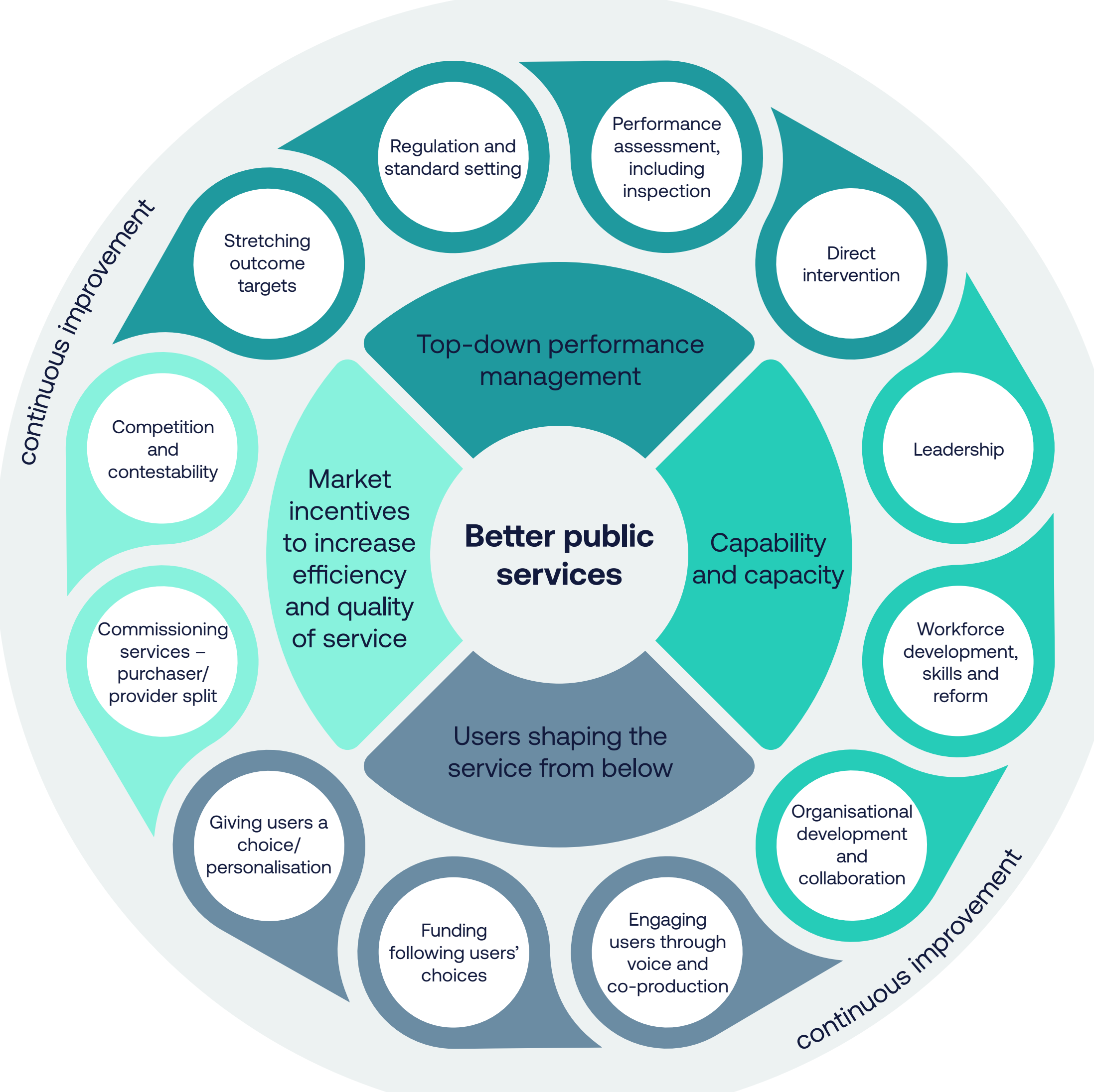
Improvement resources and expertise

The Health Foundation has been supporting improvement fellowships, projects, networks and research for more than 20 years and provides free access to a wide range of resources. The Foundation's quick guide, Quality Improvement Made Simple, includes a directory of sources of learning and support. This includes the Flow Coaching Academy (FCA), which trains staff in team coaching and improvement approaches, who then support multidisciplinary teams to identify and deliver flow improvements to specific care pathways. The Health Foundation is helping to strengthen and disseminate the evidence base behind improvement science, including through the Healthcare Improvement Studies Institute at Cambridge University, the Improvement Analytics Unit and work with the BMJ.

The Q community brings together thousands of people from all backgrounds with improvement expertise across the UK and Ireland. Q is delivered by the Health Foundation and supported and co-funded by NHS England and partners across the UK and Ireland. Q includes funding programmes, flexible peer learning and insight activities and a Q Improvement Lab, exploring specific complex challenges. As well as providing a community and long-term infrastructure that local systems could build on, Q is a source of practical expertise in the effective design and development of collaborative improvement networks.

Work on quality improvement in the NHS has been taken forward in a context in which successive governments have used an eclectic range of approaches in seeking to improve the performance of public services. These approaches included top-down performance management, users shaping services from below, market incentives and capability and capacity.[16] Governments have rarely paid as much attention to quality improvement as public service leaders at a local level, meaning that the latter have sometimes found themselves swimming against the tide.

The UK government's model of public service reform – a self-improving system



Much quality improvement work has been based in NHS trusts where clinical teams have been trained and supported to lead improvements in care. The methods used originated in manufacturing and have been adapted for use in hospitals and other care settings. A number of international healthcare systems have attracted interest for their success in improving patient safety and the quality of care and this explains the appetite to learn from the Virginia Mason Medical Centre and the IHI. The Institute of Medicine in the United States drew on experience of quality improvement in healthcare in these and other systems in its landmark report on the learning healthcare system summarised in the following figure.[17]

Characteristics of a continuously learning health care system

Science and informatics

- **Real-time access to knowledge**—A learning healthcare system continuously and reliably captures, curates, and delivers the best available evidence to guide, support, tailor, and improve clinical decision making and care safety and quality.
- **Digital capture of the care experience** — A learning healthcare system captures the care experience on digital platforms for real-time generation and application of knowledge for care improvement.

Patient-clinician partnerships

- **Engaged, empowered patients** — A learning healthcare system is anchored on patient needs and perspectives and promotes the inclusion of patients, families, and other caregivers as vital members of the continuously learning care team.

Incentives

- **Incentives aligned for value** — A learning healthcare system has incentives actively aligned to encourage continuous improvement, identify and reduce waste, and reward high-value care.
- **Full transparency** — A learning healthcare system systematically monitors the safety, quality, processes, prices, costs, and outcomes of care, and makes information available for care improvement and informed choices and decision making by clinicians, patients, and their families.

Continuous learning culture

- **Leadership-instilled culture of learning** — A learning healthcare system is stewarded by leadership committed to a culture of teamwork, collaboration, and adaptability in support of continuous learning as a core aim.
- **Supportive system competencies** — A learning healthcare system constantly refines complex care operations and processes through ongoing team training and skill building, systems analysis and information development, and creation of the feedback loops for continuous learning and system improvement.

For its part, the IHI made an early contribution on bringing about improvement at scale in a paper written to inform work on patient safety in the 100,000 lives campaign in the United States and cited at the beginning of this report.[3]

Interest in the NHS in quality improvement has included examples of trusts collaborating in improvement networks such as clinical networks, communities of practice and improvement collaboratives. The promise of these approaches is that they will achieve greater reach through shared learning. This is also the promise of integrated care systems in England, discussed further below. Evaluations suggest that collaborative approaches require substantial effort to become established and are 'neither utopia nor dystopia' in the verdict of one review.[18]

Work commissioned by the Health Foundation offered a more positive assessment by identifying the core features of effective networks and practical steps for creating them, arguing that 'Working with others to tackle a common problem creates a platform for learning and peer mutual accountability, and can also generate energy and excitement'.[19] The report added, 'Properly designed, improvement networks provide an inbuilt mechanism to spread successful change quickly, leveraging the power of social and professional connections, rather than relying on the formal chain of command of a hierarchical organisation' (ibid.).

Communities of practice and learning networks played a part in the NHS response to the COVID-19 pandemic.[20] They included networks on intensive care, remote home monitoring, and remote management of non-COVID-19 conditions. By enabling clinicians to collaborate and share information, networks facilitated the rapid evaluation and adoption of clinical practices, making use of video conferencing such as Microsoft Teams and Zoom, supported by use of WhatsApp and Twitter. In so doing, they faced challenges including lack of supportive infrastructure and shortages of staff with expertise to support rapid evaluation of frontline innovation.

Healthcare organisations and systems in other countries have used networks and a variety of improvement methods to achieve positive results under the right conditions.[21,22] The transformation of the Veterans Health Administration in the United States in the 1990s, the Canterbury District Health Board in New Zealand in the 2010s, and Jonkoping County Council in Sweden are of particular relevance to work underway currently to support improvement at scale in the NHS in England (box 2). A key lesson from high-performing healthcare organisations and systems is the time it takes to bring about improvements in care and outcomes and the need for 'constancy of purpose' along the way, to invoke Deming, one of the founders of quality improvement.

Box 2: Learning from other countries

The **Veterans Health Administration (VA)** is a large, geographically dispersed and publicly funded healthcare system that employs doctors and other staff, owns and runs hospitals and medical offices, and manages services under the auspices of the federal government. In the mid-1990s it was seen as an inefficient and unresponsive bureaucracy delivering mediocre care in need of radical reform. Its challenges stemmed in part from an over emphasis on hospital care and over-centralised management based on military style command-and-control principles.[24]

Under new leadership, the VA was reorganised into a series of regionally based integrated service networks responsible for care and resources across all settings. Network leaders were held to account for using resources effectively with a focus on patient safety and quality of care. Transparent reporting of performance was used to stimulate comparisons between networks based on key metrics and these comparisons were discussed in regular meetings between national and network leaders. Decision making was de-centralised to the lowest appropriate level, new leaders were recruited, and leaders were held accountable for their decisions.[25]

Clinical leaders focused their efforts on patient safety, quality of care and outcomes and were supported by an investment in information systems to provide them with the data needed to manage services and improve care. This resulted in much reduced use of hospitals as more care was provided in outpatient and community settings. Studies showed measurable improvements in the quality of care enabled by the use of evidence-based guidelines, decision support tools and physician alerts.[26,27] These improvements led the VA to be seen as an example of a high-performing healthcare system.[28]

The VA's transformation was based on its leaders articulating a clear vision of the future and making a series of interlinked changes that, over time, delivered results. These changes were delivered at scale and involved difficult choices, including closing hospitals or scaling back their operation in order to reinvest in services in the community. Among other things, this entailed investment in remote monitoring technology to allow patients to manage their conditions at home with visits or appointments being triggered as the need arose.[29]

It should be noted that since its transformation the VA has struggled to sustain the improvements that occurred in the late 1990s in the face of rising demand and constrained resources. Challenges include lengthening waiting times for treatment and concerns about the variable quality of care. This is a reminder that the journey to high performance is rarely linear and never one way.

Canterbury District Health Board in New Zealand serves a population of around 500,000 in the city of Christchurch and surrounding areas. Its quality improvement work has focused on integrating health and social care to tackle growing demand for care from an ageing population. Increasing use of hospital services stimulated its leaders to seek ways of providing more care outside hospitals by strengthening primary care and investing in services that helped avoid hospital admission and facilitated early discharge.

The health board's leaders worked with staff to articulate a vision based on Canterbury having 'one system, one budget'. They understood that realising

this vision depended on fully engaging staff in finding more effective ways of meeting patients' needs. This meant creating a social movement for change in which over 2,000 staff were engaged in the first six weeks in a programme known as Xceler8, beginning in 2007.

An investment was also made in providing training for staff in the skills required to improve care. Improvement methods such as Lean and Six Sigma were used, alongside visits to organisations like Air New Zealand and New Zealand Post that had achieved impressive results using these methods. The board's chief executive, David Meates, was explicit in giving staff permission to change the system.[30] These actions delivered results through the aggregation of marginal gains rather than a major breakthrough.

An example was the Health Pathways programme in which hospital doctors, general practitioners and their teams worked together to agree what the care pathway should look like for common medical conditions. This included identifying the work that general practitioners and their teams could carry out and the resources they needed to do so. As a result, more care was delivered in the community. When patients arrived at hospital, much if not all of their investigative work had already been undertaken. Health Pathways are one way in which rising demand for hospital care was moderated.

Jönköping County Council in Sweden is an elected regional health authority serving a population of around 330,000 and is widely recognised for the high-quality care it provides. Over a period of 20 years, it has pursued a population-based vision of 'a good life in an attractive county'. This includes achieving strong financial performance and a commitment to continuous quality improvement in the delivery of health and social care. Its work has been informed by a concern to deliver the best possible outcomes for 'Esther', a fictional older resident whose experience was used to enable clinical staff to map care pathways and explore how they could be improved to better meet Esther's needs.

County councils in Sweden have considerable autonomy by virtue of the devolved system of government in that country and their tax-raising powers. Jönköping's work on quality improvement initially benefited from involvement

with the IHI in the Pursuing Perfection programme. Through this programme, leaders adopted a methodology for quality improvement and applied this to services in the county's three hospitals and 34 primary care centres. The relationship with IHI was formed through contact from the top leadership team and was progressively extended to staff throughout the organisation.

Building on this experience, Jönköping established its own in-house centre for learning and improvement known as Qulturum. This centre delivers education, training and learning in quality improvement to the county council's staff, drawing on links with international experts such as Don Berwick and Paul Batalden. Thousands of staff have taken part in the programmes run at Qulturum as an expression of the council's commitment not only to quality improvement, but also to becoming a learning organisation. The results of this work over many years are evident, as Jönköping compares favourably with other county councils on measures of quality of care in national rankings.

A recent analysis has outlined the importance of the Esther project in Jonkoping's work. By asking 'What is best for Esther?', and by involving people like Esther in redesigning care, staff brought about a range of improvements. Co-production with patients and person-centredness were at the heart of this work, which over time migrated from a project to becoming a mindset among staff. The analysis emphasises the need to pay attention to the psychology of change and the motivations of staff which the authors argue may not always be seen as priorities in established quality improvement methods.[31]

Work in the NHS is currently centred on integrated care systems made up of partners from the NHS, local government and the voluntary and community sector. Integrated care systems were established on a statutory basis in July 2022. They comprise an integrated care board (ICB) which is a statutory NHS organisation responsible for managing the NHS budget and arranging for the provision of health services in the ICS area, and an integrated care partnership (ICP) which is a statutory committee jointly formed

between the NHS integrated care board and all upper-tier local authorities that fall within the ICS area. The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.

The work of ICSs is focused on four aims:

- To improve outcomes in population health and care.
- To tackle inequalities in outcomes, experience and access.
- To enhance productivity and value for money.
- To support broader social and economic development.

The Hewitt review of ICSs referred to them becoming 'self-improving systems' and identified the need for systems to develop their own improvement capacity. In concept, this might involve ICSs facilitating improvement in the system, identifying areas in which the system can lead improvement with and among partners, and focusing on improvement of the system itself.

The Hewitt review also referred to the NHS improvement approach being developed by NHS England and the role of 'some overarching principles that can be adopted locally' in this approach. Importantly, the review asserted that:

'Cross-ICS sharing and learning via peer-to-peer networks and collaboratives will strengthen ICSs' approaches to collectively leading improvement.'

The NHS improvement approach was subsequently outlined in the report of the NHS delivery and continuous improvement review. It described the approach as NHS improving patient care together (NHS IMPACT for short) and put forward ten recommendations consolidated into three actions:

- Describe a single shared NHS improvement approach.
- Co-design with health and care partners a leadership for improvement programme.

- Establish a national improvement board to agree the small number of shared priorities on which NHS England, with providers and systems, will focus improvement-led delivery work.[2]

These actions are aligned with the new operating framework for NHS England and the Hewitt review and they recognise the need to strengthen horizontal and bottom-up approaches to improvement as an alternative to top-down performance management. The Health Foundation has proposed five principles for implementing NHS IMPACT.[23]

NHS IMPACT is based on a number of components that are described as 'the DNA of all evidence-based improvement methods'.[2] They are building a shared purpose and vision, investing in people and culture, developing leadership behaviours, building improvement capability and capacity, and embedding improvement into management systems and processes. NHS England expects that all systems and providers will adopt an approach consistent with these components.

In focusing on the work of ICSs, this report illustrates the variety of approaches adopted at a local level and distils the common themes in these approaches. It also proposes ways in which the Health Foundation and the NHS Confederation can support ICSs recognising – as discussed earlier – that national leadership of improvement work has waxed and waned. The balance to be struck between national and local leadership in NHS IMPACT needs careful consideration as this work evolves.

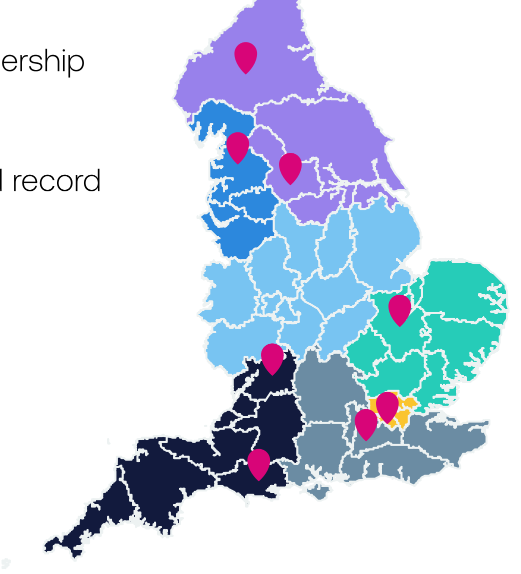
The experience of ICSs

How then are ICSs seeking to become self-improving systems?

This report describes the early work of a number of systems (see figure) identified as being at the forefront of work on improvement at scale by informants familiar with ICSs and others involved in the quality improvement community. Leaders in these systems were interviewed (around 40 in total) and data from interviews were supplemented by a review of plans and reports shared by these systems. Contact was also made with people working on quality and service improvement in adult care, local government, the NHS in Scotland and quality improvement experts familiar with experience in England and other countries.

System case studies

- North East and North Cumbria
- West Yorkshire Health and Care Partnership
- Lancashire and South Cumbria
- The Thames Valley and Surrey shared record
- Dorset
- One Gloucestershire
- Cambridgeshire and Peterborough
- Surrey Heartlands



The main part of this report outlines the approaches used by the ICSs chosen for inclusion in this study. This is followed by a summary of relevant work in local government, Scotland and adult care. The report concludes with a review of emerging themes, the implications for integrated care systems as they seek to lead improvements in health and care at scale, and how they can be supported in this work.

Up to six people involved in improvement work were interviewed in each system in order to obtain perspectives from leaders in system, organisational, managerial and clinical roles. The research that lies behind the report benefited from discussions in three roundtables involving leaders from inside and outside these systems. The principal focus was how ICSs were seeking to bring about improvement at scale, building on the legacy of partner organisations and including work within the places and neighbourhoods that make up systems.

It is important to emphasise that at the time the fieldwork was conducted, ICSs had been in existence as statutory bodies for around one year. Many interviewees were keen to stress that it was too early to demonstrate tangible improvements from the work they were engaged in and that more time was needed to be confident that the approaches they were taking would deliver results. These caveats underline the importance of treating the conclusions of this report as tentative and subject to updating and revision as experience accumulates.

Case studies

	North East and North Cumbria	West Yorkshire	Lancashire and South Cumbria	Gloucestershire
Legacy	Receptive context based on the North East Transformation System, Cumbria Learning and Improvement Community, and improvement expertise in several NHS trusts.	Foundations for improvement at scale laid from 2016 as STP, with improvement expertise in several NHS trusts and through collaboration in the West Yorkshire Association of Acute Trusts (WYAAT) and mental health collaborative.	Improvement expertise already established in some NHS trusts and a provider collaboration board worked as a joint committee of the five NHS trusts in the system.	Improvement expertise already established in NHS organisations using various methods, including QSIR (quality, service improvement and redesign), which created a receptive context for the Gloucestershire improvement community.
System leadership	Strong commitment to partnership with local authorities, VCS (voluntary and community sector) and others in developing a learning and improvement community of staff involved in improvement drawing on an explicit theory of change.	Strong commitment to partnership with local authorities, VCS and others underpinned by distributed leadership involving leaders from across the system taking responsibility on shared priorities.	Strong focus on recovery and transformation to tackle financial deficits and achieve a sustainable model of care.	Strong focus on improving population health and tackling health inequalities working with local authorities, VCS organisations and other partners.

	North East and North Cumbria	West Yorkshire	Lancashire and South Cumbria	Gloucestershire
Provider collaboratives	Established in 2019 by the 11 NHS foundation trusts in the system working as a provider leadership board and in the process of establishing its role.	Three collaboratives work closely with the integrated care board; WYAAT and the mental health collaborative operate through a committee in common across their respective NHS trusts and play a major part in improving clinical care aligned with the ICS plans.	The provider collaboration board leads improvement work in NHS trusts using common principles of improvement, making use of the Engineering Better Care approach.	The functions of a provider collaborative are integrated into the system's structures, alongside collaborations with other systems, eg. on mental health.
Place partnerships	Fourteen place partnerships based on local authority boundaries lead improvements in their areas.	Five place partnerships lead improvements in their areas, with the ICS delegating responsibilities for local improvement to these partnerships comprising staff from the ICB, local authorities, NHS providers and the voluntary and community sector.	Four place partnerships lead improvements in their areas, with the ICS delegating responsibilities for local improvement to these partnerships.	Integrated locality partnerships each aligned with one of six district councils are where place-based improvement is undertaken.
Neighbourhoods	Primary care networks lead work on improving health and care in neighbourhoods.	Integrated neighbourhood teams are being developed in each of the 52 neighbourhoods under the leadership of place partnerships.	Primary care networks lead work on tackling health inequalities in neighbourhoods using data and improvement methods.	15 primary care networks lead work on improving health and care in neighbourhoods with an explicit commitment to improvement projects being led by PCNs.

	North East and North Cumbria	West Yorkshire	Lancashire and South Cumbria	Gloucestershire
Other features	The involvement of people with lived experience is valued highly and staff experience and engagement also figure prominently. The local health innovation network has been a partner on some issues. Local universities have supported work on human learning systems and evaluation of the improvement strategy.	The local health innovation network has a prominent role in supporting innovation across West Yorkshire and there is an explicit commitment to tackling inequalities under the West Yorkshire Health Inequalities Academy.	The Population Health and Health Equity Leadership Academy is developing leaders to take forward work on health inequalities.	The improvement community seeks to be open and inclusive, using simple shared language, with the aim of developing a thriving improvement culture based on a playbook that draws on expertise in the system. The local health innovation network has a good relationship with the system.
Examples of improvement work	Peer-to-peer learning has been used to reduce ambulance handover delays. A discharge summit was held with aim of reducing lengths of stay in hospitals. Community of practice has been used to improve urgent and emergency care performance based on 'all teach and all learn'. The provider collaborative has led on elective recovery and GIRFT and on clinical services In all cases, data analysis has supported improvement.	Wakefield's work on managing/reducing demand for hospital care though integration with local authority and use of data to identify high intensity users. WYAAT's work on elective recovery including use of GIRFT, review of fragile specialties, and work with Cancer Alliance on waiting times.	The Engineering Better Care approach is being applied to frailty. The provider collaboration board is leading work on elective recovery and cancer. Primary care networks are leading work on health inequalities with a focus on listening to what matters to people in different communities.	Cancer care has been a priority since 2016 and improvement has focused on diagnosis, referrals and streamlining pathways. The Warm Home prescription project offers financial support with energy costs for patients with chronic medical conditions and has helped people remain independent and relieved pressure on services. Community-based clinics for COVID-19 patients who required ITU and HDU care won the patient-centred care award of the Intensive Care Society.

	North East and North Cumbria	West Yorkshire	Lancashire and South Cumbria	Gloucestershire
External help	NENC has involved leaders from international exemplars such as Cincinnati Children's Hospital and Jonkoping County Council. The advice and input of improvement experts Helen Bevan and Sue Holden has been sought. The Health Foundation is supporting the system in developing and evaluating its work.	West Yorkshire has drawn on learning from the Canterbury District Health Board in New Zealand and one of the board's former leaders now works in Wakefield. Leeds place partnership is partnering with the Staten Island health system in New York.	David Fillingham (formerly of the NHS Modernisation Agency and AQUA) and John Clarkson, University of Cambridge, have provided support. NHSE and the IHI are working with LSC in tackling inequalities in cancer care and outcomes. The system is one of seven accelerator sites participating in the IHI/NHSE Core20PLUS5 Breakthrough Series Collaborative Programme.	Improvement leaders are part of the Q community convened by the Health Foundation. The Delivering Improvement Network established by improvement leads in Gloucestershire Hospitals is a forum for provider-based colleagues from across the country to share ideas and experience. Newton Europe is working with the system in the transformation of urgent and emergency care. The work of the Canterbury Health Board in New Zealand informed the early stages of the system's work.

	Cambridgeshire and Peterborough	Thames Valley and Surrey	Surrey Heartlands	Dorset
Legacy	Improvement expertise already established in NHS trusts but operating in silos and with some parts of the system better served than others.	Work started in 2018 as part of a national initiative on local health and care records exemplars and involves collaboration between three systems.	An established relationship between the NHS and the county council. NHS trusts with varying degrees of improvement expertise including one involved in the VMI partnership with the NHS that was rated outstanding by CQC.	Improvement expertise already established in NHS trusts using various methods.
System leadership	Focus on improving population health, tackling health inequalities and being environmentally and financially sustainable.	Focus on ensuring that health and care professionals have safe and secure access in near real-time to a comprehensive care record. Citizens are empowered to manage their own health and care, and patient data is used to improve population health.	Focus on improving population health through collaboration with local authorities and voluntary and community sector organisations with a particular interest in developing clinical and other leaders.	Focus on improving population health and tackling health inequalities working with local authorities, voluntary and community sector organisations and other partners.
Provider collaboratives	Alongside two place partnerships, the system has two accountable business units for mental health, learning disability and autism; and maternity and child health services. There is no provider collaborative but there is a strategic commissioning unit.	The programme covers 12 NHS trusts, 335 general practices, three county councils, six unitary authorities and 14 district and borough councils.	Three acute trusts and the mental health trust have recently formed a provider collaborative.	The provider collaborative brings together the three NHS trusts in Dorset to work on shared corporate services and clinical services including elective recovery.

	Cambridgeshire and Peterborough	Thames Valley and Surrey	Surrey Heartlands	Dorset
Place partnerships	Two place partnerships centred on Cambridge and Peterborough are where local improvement is led and supported by health and care teams.	Place partnerships reflect arrangements in each of the systems involved.	Four place partnerships lead work on improvement at a local level with local authorities and VCS organisations closely involved.	Two place partnerships led by local authorities lead improvements in their areas with the ICS delegating responsibilities for local improvement to these partnerships.
Neighbourhoods	22 primary care networks are establishing integrated neighbourhood teams to better understand and respond to local needs.	Primary care networks in each system lead improvement work in neighbourhoods.	Primary care networks lead improvement work in neighbourhoods with other partners.	

	Cambridgeshire and Peterborough	Thames Valley and Surrey	Surrey Heartlands	Dorset
Other features	A chief clinical improvement officer from a general practice background leads work to expand improvement beyond individual organisations, with the aim of moving towards a more consistent and joined-up approach across the system, including general practices and other primary care providers. The system has received support from the Health Foundation to establish an adopting innovation hub.	A small team has dedicated responsibility for the programme and most of the work is done locally by staff with relevant expertise using various improvement methods underpinned by common principles. The role of the dedicated team includes providing data and evidence of what works and recognising that improvement is most effective when it is led by staff 'doing the work'.	A quality improvement collaborative brings together staff with improvement expertise from across Surrey and has developed a quality management system based on common principles. Leadership development currently focuses on the Growing System Leaders programme, which builds on the Surrey 500 programme run by the Surrey Heartlands Health and Social Care Academy. The local health innovation network was a partner in the development of the academy. Surrey Heartlands is one of the systems involved in the Thames Valley and Surrey Shared Care Record work.	Data drawn from the Dorset intelligence and insight service, covering health and care, informs improvement work down to the small area level.

	Cambridgeshire and Peterborough	Thames Valley and Surrey	Surrey Heartlands	Dorset
Examples of improvement work	'Call before you convey' provides ambulance crews with a single point of access to advice and support to enable people to be cared for at home and reduce pressure on emergency care services, supported by extended urgent community response services.	Data from the shared care record has been used to understand variations in health outcomes and how they change as a result of interventions General practices have been engaged in work on the management of high blood pressure to reduce variations between affluent and deprived areas and identify more people with undiagnosed hypertension Remote monitoring technology has been rolled out to care home residents and high-risk patients with chronic conditions, supported by two monitoring hubs, building on work during the response to COVID-19.	East Surrey place is working to make a step change to discharge planning in partnership with the VMI by mapping existing processes and involving patients and carers. The primary care network serving Merstham is using a health creation approach – described as 'start small and build big' – to understand what matters to local people on a housing estate and working with them to find solutions.	The development of outpatient assessment centres known as Dorset health villages in high street locations. The Ageing Well programme supports people to live independently and has reduced hospital use among older people, who comprise a significant part of the Dorset population.

	Cambridgeshire and Peterborough	Thames Valley and Surrey	Surrey Heartlands	Dorset
External help	System leaders have focused on making better use of improvement expertise in the system rather than bringing in external help, although the 'Call before you convey' initiative drew on learning from Oxford.	With its origins in a national initiative, work on the shared care record benefited from being part of Combined Intelligence for Population Health Action, which enabled testing different approaches in different areas and sharing worthwhile interventions and innovations.	The head of research and engagement for Surrey County Council and Surrey Heartlands brought expertise from work with Ipsos Mori to lead a unique citizens' panel, representative of the local population across the ICS. He is now leading a social research project into creating and embedding a connected culture across the workforce to enable effective system integration.	The system's chief strategy and transformation officer comes from a clinical and private sector background and is working at pace with colleagues on improvement and cultural transformation. The system is working with a local university on a framework to support cultural change through the lens of improvement.

Case study one: North East and North Cumbria (NENC) – Being the best at getting better

The North East and North Cumbria Health and Care Partnership is one of the largest and most geographically dispersed integrated care systems in England. Serving more than three million people across over 5,000 square miles, a size comparable to Wales, and with a budget of £6.6 billion, the partnership comprises 11 NHS foundation trusts, 64 primary care networks, and 14 local authority areas. The quality of health and care services is consistently rated among the best in the NHS, and the system is rated as two in the outcomes framework used by NHS England to assess performance.

The system has set out a vision of creating better health and wellbeing for all, based on four goals:

- Longer and healthier lives.
- Fairer outcomes for all.
- Better health and care services.
- Giving young people and children the best possible start in life.

Supporting goals identify specific targets such as to reduce the gap in life expectancy for the most excluded groups and to reduce smoking rates among adults to 5 per cent or below by 2030. These goals recognise that the partners who make up the system face challenges in improving the health of the population, notwithstanding the provision of good care. These challenges relate to high levels of deprivation and wide inequalities in the population.

In seeking to deliver this vision, Sam Allen, chief executive of the ICB, brought partners together to discuss what they wanted from the partnership. It was agreed that there was an opportunity to learn from each other and to work towards the ambition of being ‘the best at getting better’ (a phrase borrowed from Cincinnati Children’s Hospital) by establishing a learning and improvement community. Place partnerships based on the 14 local authority areas in the system lead improvement for their populations.

Building a learning and improvement community

The community is building on the positive legacy of improvement work in NENC, for example in the North East Transformation System and the Cumbria Learning and Improvement Community. Work to create a community started before the partnership became a statutory body in July 2022. The results fed into a launch event in September 2022, attended by around 300 people, in which the lived experiences of people in NENC were prominent. All learning events now include testimony films to bring people’s experiences to the fore.

Seven key priorities for improvement were agreed at the event:

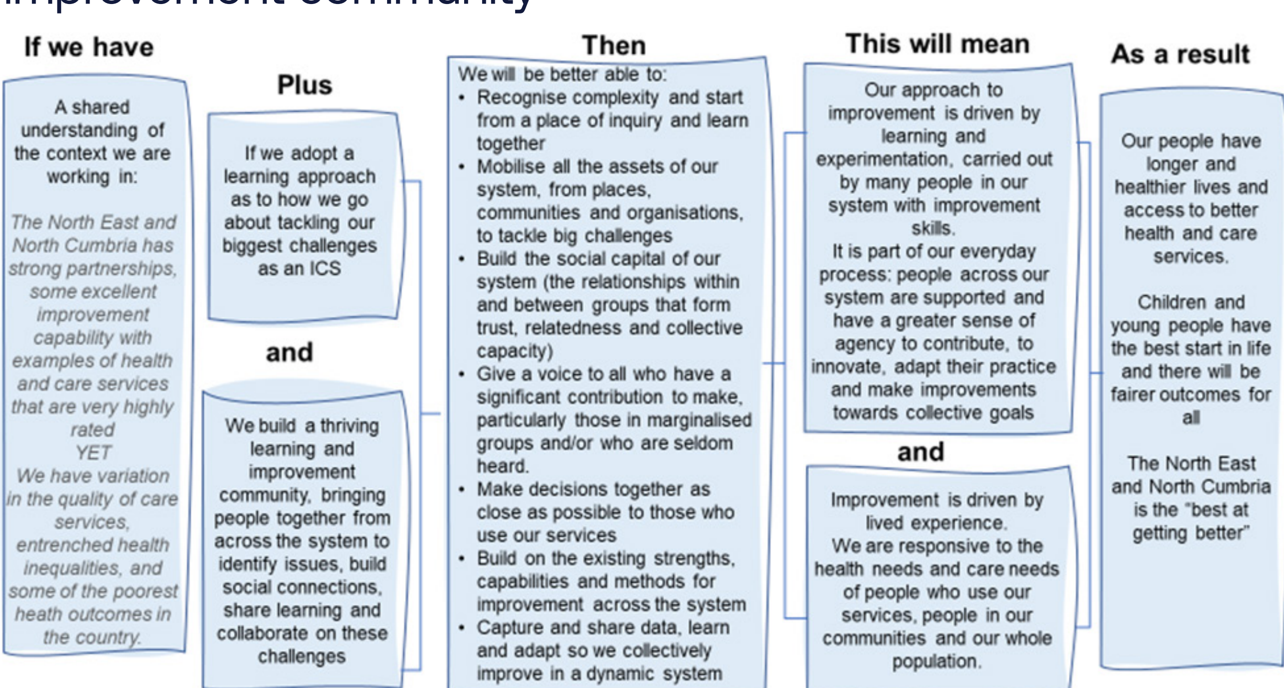
- Shifting from treatment to prevention.
- Building and developing the social care workforce.
- Safe transfer/discharge out of hospital.
- Workforce retention and wellbeing.
- Waiting times and crisis support for children and adolescent mental health services.
- Collaborative leadership across the system.
- Sharing learning and joining up as a system.

A multidisciplinary and multiagency steering group, chaired by the ICS chair Sir Liam Donaldson, meets bi-monthly to track progress against these priorities and promote shared learning.

System leaders are clear that their role is to act as the convenor and facilitator of the learning and improvement community. Priority has been given to building trust among partners, investing in collaborative relationships, and fostering networks to facilitate knowledge exchange. This is in the context of an NHS in which competition and organisational autonomy have until recently been guiding principles, perhaps nowhere more so, in the view of one interviewee, than in the north east.

At a recent workshop, system leaders agreed a revised theory of change for the learning and improvement community (see below). There is a strong emphasis on learning, experimentation, complexity, curiosity and a commitment to create knowledge-sharing systems. A senior leader interviewed for this work made the point that the language used by colleagues steeped in improvement work could be difficult to understand and made a plea for it to be translated to ensure it was comprehensible for others.

Theory of change for the learning and improvement community



Recent developments include work to capture improvements being led in the places that make up NENC, which system leaders acknowledge are not always visible across the system, and a training programme designed to unlock community power developed with the think tank, New Local.

Examples of improvements

An example of how the learning and improvement community operates is work to reduce ambulance handover delays. Areas experiencing longer delays visited areas with shorter delays to observe and learn from their peers. A standard operating model was then agreed for the whole system and this helped to bring about big reductions in delays. Rapid improvement events with staff 'doing the work' were at the heart of this initiative. The support of senior leaders was a key enabler in progress being made.

Another example is a discharge summit held in March 2023, drawing on international as well as local expertise. One of the outputs from the summit was a driver diagram including the interventions required to achieve a 10 per cent reduction in the average length of stay in six months. This has evolved into the Safe Transfer of Care Improvement Collaborative involving 60 improvement leads from across the system. As in other improvement work, there was a strong focus on the use of data to understand and reduce discharge delays, as well as changes in behaviour and working practices among the teams delivering care.

> ... even the most challenged organisations have experience to contribute in a collective endeavour to improve.

In the case of urgent and emergency care, improvement has focused on three priorities: enhanced clinical triage, urgent primary care and system flow. Activities included three community of practice events and two winter planning events. A philosophy of 'all teach and all learn' has been adopted in recognition that even the most challenged organisations have experience to contribute in a collective endeavour to improve. Early results include reductions in

falls-related admissions to hospital as a result of the community response service and reductions in NHS 111 call handling times.

Work is also underway to challenge medicalised approaches to health and care and recognise the many examples of communities leading initiatives to create better health and wellbeing.

The provider collaborative

The NENC ICB works in partnership with the NENC provider collaborative. The latter was established in 2019 and comprises the 11 NHS foundation trusts within NENC. The relationship between the ICB and the provider collaborative is set out in a responsibility agreement that describes how the collaborative supports the delivery of the ICB's integrated care strategy.

At the time of writing, this involves the collaborative leading a comprehensive elective recovery programme, including on GIRFT (Getting It Right First Time), clinical services strategy, key enablers to collaboration such as workforce and estates, and implementation of an aseptic manufacturing hub. An NHS trust chief executive argued that the collaborative was still developing its own approach to improvement and the capacity needed to deliver it.

Matt Brown, managing director of the provider collaborative, explained that it operates as a formal partnership but unlike in West Yorkshire (see below) has chosen to operate as a provider leadership board at this point, with the potential to evolve into a committee in common in time. A core group of around 15 staff are supported by many hundreds of colleagues drawn from the 11 foundation trusts within NENC in delivering the collaborative's programmes.

A trust chief executive argued that the priorities identified by the ICB were not always the most urgent issues facing foundation

trusts. It was therefore important that trusts had the capacity they needed for improvement work as well as playing their part in the collaborative and the ICB. She added that there were challenges in making an effective contribution in a system as large and geographically dispersed as NENC, although work in the places that make up the system, for example to achieve closer vertical integration with other partners, was a priority.

Matt Brown added that leaders in the collaborative and the ICB were figuring out how best to work with each other in a set of organisational arrangements that were still emergent, echoing experience in Lancashire and South Cumbria described below.

Other support

NENC has benefited from the involvement of national improvement experts such as Helen Bevan of NHS Horizons and Sue Holden of AQUA, as well as local academic expertise. Its work has also attracted interest and support from the Health Foundation to enable independent evaluation of progress and to facilitate links with improvement activities across the four nations of the United Kingdom. The health innovation network has been a valued partner on innovation.

The aligned approach to improvement developed in NENC draws on some of these contributions.

North East and North Cumbria Learning and Improvement Community

One of the assets of NENC is a network of improvement staff in partner organisations and the experience they are able to bring, albeit with more to do to involve all of those with expertise to offer in NHS trusts. Many of these staff are clinicians.

Emerging lessons

System leaders and their partners recognise that it is 'early days' and emphasise the need to embrace humility in building on progress to date. They identified a number of barriers, including challenges in releasing staff in the face of unrelenting workload pressures and lack of technical skills in some places. Gaps in data on patient and staff experience were also mentioned.

The requirement placed by the government on ICSs to cut management costs by 30 per cent is a further barrier, in that it reduces management capacity at a time when ICSs are faced with

increasing demands. System leaders explained that they also see this as an opportunity to be clear on the role of the ICB and the functions it is best placed to perform. This includes agreeing with partners the role of place partnerships, providers and the provider collaborative.

Leaders in NENC recognise that performance management through NHS England could be a hindrance if it runs counter to work on relationship building. A potential safeguard against this is NHS England's new operating framework, with its commitments to greater devolution of decision-making and systems taking on a bigger role in responding to NHS trusts facing challenges. As this happens, a trust chief executive argued that if the ICB itself comes to be seen as a performance manager, this could conflict with the emphasis placed on learning and improvement by system leaders.

The part played by Sam Allen and Annie Laverty, executive director of improvement and experience, was highlighted in interviews. Specifically, they were praised for adopting an inclusive approach and the involvement of service users and others with lived experience. A trust chief executive reported Sam and Annie had shown 'great collaborative leadership' in gaining support from their peers in local authorities and NHS trusts. Annie emphasised the importance of celebrating successes and keeping 'fun' in improvement work as a way of raising staff morale and valuing discretionary effort at a time of intense workload pressures.

Case study two: West Yorkshire – Better health and wellbeing for everyone

The West Yorkshire Health and Care Partnership (WYHCP) is an integrated care system serving 2.4 million people in Bradford, Halifax, Huddersfield, Leeds, Wakefield and their surrounding areas. With a budget of £5.3 billion, the partnership comprises ten NHS trusts, 52 primary care networks, two community interest companies, over 10,000 voluntary sector organisations and six local authority areas. Like the rest of England, there are challenges in delivering constitutional standards as the partnership focuses on recovering performance in line with national requirements, alongside targets to deliver local priorities.

Most organisations are assessed as high-performing and the system was rated as 2 in NHS England's outcomes framework. Where there are performance challenges, the partnership works to bring about improvements in line with national standards. Much of the work of the system is delivered in the five places that make up West Yorkshire. Places have their own committee of the ICB, are allocated the majority of the funds for the partnership and collaborate when this makes sense.

Rob Webster, chief executive of the integrated care board, said "Our partnership exists to improve outcomes for people in West Yorkshire. We have a recent history of delivering through collaboration before, during and now living with COVID-19. Our next big shift is to become a self-improving system, with the culture and infrastructure required to deliver this embedded in all we do." Rob's leadership and willingness to take risks have shaped the approach taken in the system.

The system's five-year plan, Better Health and Wellbeing for Everyone, published in 2020, set out four aims, which have been reiterated in an updated strategy in 2023:

- Reduce health inequalities.
- Manage unwarranted variations in care.
- Secure the wider benefits of investing in health and care.
- Use collective resources wisely.

The plan identified ten 'big ambitions' related to these aims, including to increase the years of life that people live in good health, tackle the inequities faced by people with a learning disability, reduce suicides, and realise the economic benefits of investing in the health and care system. A commitment to partnership between the NHS, local authorities, the voluntary and community sector and others permeates the system's work.

There is also a commitment to devolve decision-making to the places, neighbourhoods and providers that have formed collaboratives across West Yorkshire and in places. A distributed leadership model has been in place since 2016, in which leaders from across the system share responsibility for the system's work and delivery of priorities. Place partnerships are working with primary care networks in the system's 52 neighbourhoods to develop integrated neighbourhood teams.

... leaders from across the system share responsibility for the system's work and delivery of priorities.

Tackling inequalities in health outcomes is a high priority. The COVID-19 pandemic highlighted the challenges facing people from black, Asian and ethnic minority communities, leading to an independent review on what more could be done to tackle the health needs of these communities. One of the outcomes was the establishment of Health Equity Fellowships through the West Yorkshire Health Inequalities Academy, which provides a focus for a collaborative approach to narrowing the health and wellbeing gap in the system.

Improvement work

Ian Holmes, director of strategy and partnerships, and his colleagues James Thomas (medical director) and Esther Ashman (associate director of strategy), explained that improvement work is made up of a number of strands overseen by an inclusion, innovation and improvement board:

- Four provider collaboratives covering acute hospitals; community providers; mental health, learning disability and autism services; and hospices.
- Place-based improvement led by local partnerships.
- Research and innovation with universities and the local health innovation network.

System leaders felt it was important to 'go with the grain' of established improvement work in NHS trusts and other partners and to support partners to learn with and from each other. The latter includes adapting experience in local government of sector-led improvement in the approach taken to system oversight and assurance.

They emphasised too the importance of relationship building and argued that this had been underway since 2016, when sustainability and transformation plans and partnerships began work. The resulting 'culture of curiosity and collaboration', as well as the appointment of some new leaders, created a strong foundation on which to build. A good example is the work of the West Yorkshire Alliance of Acute Trusts (WYAAT) which, as an established provider collaborative, has a track record of delivering improvement at scale.

Provider collaboratives

WYAAT was set up in 2016 by the chief executives of the six NHS acute trusts in the system. A memorandum of understanding was agreed between the trusts with an initial focus on tackling

unwarranted variations in care together and working to provide services to a whole population. WYAAT works as a committee in common with a board of trust chairs and chief executives meeting quarterly and a programme executive of chief executives that meets monthly. Assurance groups of other executive directors in the six trusts help facilitate peer support and shared learning. Funding comes from the acute trusts involved, which contribute on a 'fair shares' basis.

WYAAT has a small core staff supplemented by clinical leaders and managers working for the acute trusts. Major pieces of work are led by clinicians who usually engage with peers from across the system. WYAAT agrees its own work programme and collaborates with the integrated care board to ensure alignment with system aims and priorities.

Governance is based on the committee agreeing collective support for shared business cases and these are then signed off by each trust board. An indicator of success is that proposals approved by the committee have never been rejected by trust boards. Its modus operandi has the virtue of offering clarity on decision-making and accountability.

Lucy Cole, director of WYAAT, explained that a review of vascular surgery in 2017/18 was the first major test of these arrangements. Following a clinical senate review, WYAAT explored options for reducing the number of arterial centres from three to two. Agreement was reached on how to do this and WYAAT's recommendations were approved by commissioners; a significant achievement in the view of those involved. As a result, WYAAT was able to 'pick up the pace' on other challenging issues.

Current priorities include work on fragile specialties, where actions range from short-term mutual aid to long-term service transformation, and on imaging where 12 special interest groups have been established to enable standardisation and new ways of working. WYAAT leads on elective recovery for the partnership and

networks have been established in high volume, low complexity surgical specialties to improve access to care and act on reports from GIRFT. This builds on good practice, with Calderdale and Huddersfield Foundation Trust seen as an exemplar by the GIRFT programme.

A similar approach is being used in medical specialties such as neurology and dermatology. The aspiration is to involve clinicians from beyond secondary care, where appropriate, in work on shared care pathways. This will be particularly important on issues where place partnerships lead the implementation of recommendations coming out of WYAAT. WYAAT members bring the work they are doing in places to the collaborative, as in pioneering work on tackling inequity of waiting for people from protected groups at Calderdale and Huddersfield.

Lucy Cole acknowledged that in the initial stages there were concerns that Leeds Teaching Hospitals NHS Trust, as one of the biggest tertiary centres in the country, would exert too much influence over WYAAT, but trust chairs and chief executives worked hard to show this was not the case. WYATT's decision to respect existing improvement approaches and not mandate a single method helped in this process.

Lucy Cole and Ian Holmes emphasised that WYAAT works collaboratively with the ICB in the delivery of the system's plans. This was facilitated by a positive relationship between the ICB chief executive, Rob Webster, and Julian Hartley, who was trust chief executive in Leeds at the time and was instrumental in WYAAT's establishment. Hartley reported that WYAAT had exceeded his expectations as a means of acute trusts working together to improve services at scale.

WYAAT has strong ties to the Cancer Alliance and has helped ensure that cancer services maintained a high priority during the pandemic. Collaboration has secured one of the lowest rates of 62-day cancer backlog in the country; delivered an improved and

more sustainable model for non-surgical oncology; and supported the restoration of cancer care following the pandemic. In particular, the number of urgent suspected cancer checks in West Yorkshire has doubled in the last ten years, with the Faster Diagnosis Standard achieved last year.

Place partnerships

Five place partnerships provide a focus for much of the local improvement work in West Yorkshire, including in Wakefield.

The accountable officer for Wakefield Health and Care Partnership, Jo Webster, whose role is shared between the council, an NHS trust and the ICB, explained how partners collaborate to improve health and care. Their journey started with involvement in the new care model vanguards in 2018 and the devolution of what were then clinical commissioning group functions to provider partnerships. Learning from Canterbury District Health Board in New Zealand had proved valuable in the use of alliance contracts and seeing Wakefield as having 'one system with one budget', to borrow the phrase used in Canterbury.

Jo argued that whole-system planning, alignment of investment plans, shared financial risks, and an integrated workforce strategy plan were important building blocks in the Wakefield Health and Care Partnership. Her view was that national leaders should actively encourage the more widespread adoption of these approaches to create the right incentives for improvement at scale in all systems. This meant being willing to challenge organisational autonomy, which was often a barrier to change.

The results became clear in improvements in waiting times for child and adolescent mental health services and planned care, and more collaborative relationships between clinicians in hospital and the community. Joint work on hospital discharge led to increased use of domiciliary care, reduced use of residential care and lower overall

costs. Jo emphasised the importance of changes in mindsets in enabling her and colleagues ‘to do the right thing’ without being constrained by organisational loyalties and attachments.

> “By supporting people in their own homes, investing in rehabilitation with the local authority, and focusing on timely discharge, the trust … cut the number of beds for the Wakefield adult population by 30.”

Len Richards, chief executive of Mid Yorkshire Teaching NHS Trust, and Carolyn Gullery, the trust’s chief operating officer, explained that a small cohort of high-risk adults accounted for a high proportion of hospital bed use. By supporting people in their own homes, investing in rehabilitation with the local authority, and focusing on timely discharge, the trust had reduced lengths of stay and cut the number of beds for the Wakefield adult population by 30. The trust’s integrated care team and the council’s reablement team service work together to provide an urgent community response to the needs of this cohort, who are at high risk of extended hospital stays.

These improvements were delivered by frontline staff when data on hospital use was shared with them. The impact became evident within three months of the work starting and Len reported that, as a result, the trust, which is responsible for both hospital and community health services, had created headroom for the coming winter. The use of routine data to understand demand for care and generate insights was at the heart of the progress made (see figure). Work is also underway to link patient data from different sources to create a more complete picture of patients’ health and care needs. The intention is that linked data will enable work on neighbourhood profiles, predictive modelling to support winter planning, and population segmentation.

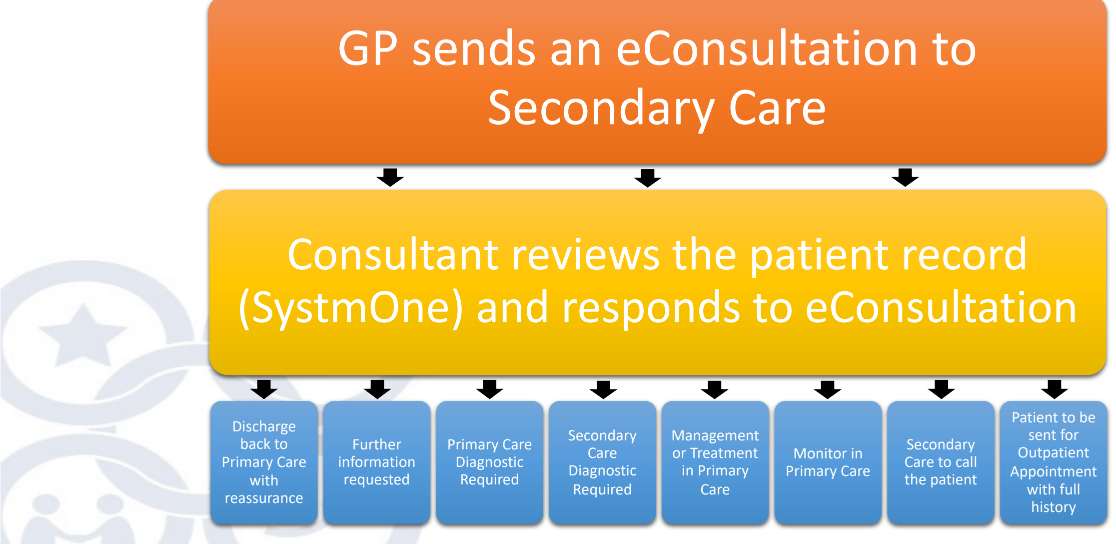
Creating a data-driven culture

Data can be applied everywhere, and data insights can come from anywhere...

In 2022/23, its first full year of operation, the partnership's work encompassed mental health services; rehabilitation and reablement; intermediate care; social prescribing support for people on waiting lists to enable them to wait well; and a roving health inclusion team to provide outreach care.

Leaders in Wakefield highlighted the Shared Referral Pathway as a notable innovation, involving primary and secondary care and independent providers. Since April 2022, it has resulted in over 4,400 patients who would have historically been referred for secondary care, receiving this support within days without needing a referral and a potentially long wait to be seen in clinic. Around 2,000 clinically unnecessary cardiac investigations have been avoided. The programme is saving time for clinicians and patients. Over the coming months the pathway will support major improvements in dermatology, gastroenterology and neurology.

What is the shared referral pathway?



Research and innovation

Health Innovation Yorkshire & Humber works with three integrated care systems including West Yorkshire. Its role is to support innovation and improvement in collaboration with ICSs and other partners. Some of its work relates to national priorities, for example patient safety, and some to local priorities such as those in West Yorkshire's own plans.

Richard Stubbs, chief executive of Health Innovation Yorkshire & Humber and chair of the Health Innovation Network, explained that its staff are embedded in the ICS. This includes leading the work of the West Yorkshire innovation hub, established in April 2022 and described by Richard as an 'import/export mechanism' able to identify and share examples of innovation and best practice in the three Yorkshire ICSs and further afield. One of the hub's roles is to facilitate relationships with industry and universities.

A current project on ambulance conveyances is exploring the relationship between use of ambulances and deprivation. The aim of the project is to understand what can be done in the community to support people and reduce demand on emergency services. A proof-of-concept approach is being used in Wakefield, informed by analysis of relevant data, and when this has been

tested the intention is to spread the learning and adapt the solution throughout the system.

The health innovation network is also supporting the roll out of the Healthy Hearts programme that originated in Bradford and is being adapted across West Yorkshire. The focus of the programme is the prevention of heart disease through more effective management of high blood pressure, high cholesterol levels, and diabetes. This is one of the ways the system is seeking to reduce inequalities in health outcomes in the population.

Emerging lessons

System leaders in West Yorkshire reported a number of barriers to progress. They included the challenge for ICB staff in making a transition from commissioning roles to working in an organisation committed to collaborative engagement with partners. There is also the challenge of ICBs being put in the position of overseeing the performance of NHS trusts and of themselves being regulated by NHS England.

This point was reinforced by Lucy Cole in the provider collaborative, who expressed concern at the constant 'checking and reporting' requirements imposed by NHS England that diverted time from work to improve performance. For both the ICB and the provider collaborative, operational pressures were both a stimulus to accelerate improvement work, and a distraction from efforts to take forward the longer-term aims and ambitions in the system strategy.

Jo Webster reported that progress depended on changes in cultures and behaviour and this had been facilitated by the permissive approach taken by system leaders. By building trust and confidence in working differently, it had been possible to overcome obstacles, underpinned by local organisational leaders giving her and colleagues authority to make changes. Jo's own role in three organisations had contributed to progress being made.

Case study three: Lancashire and South Cumbria – Recovery and transformation

The Lancashire and South Cumbria (LSC) ICS serves a population of around 1.7 million people across a large geographical area. It comprises several towns such as Blackburn, Burnley, Lancaster and Preston, seaside resorts including Blackpool, Morecambe, and Barrow-in-Furness, and an extensive rural hinterland. The M6 motorway runs the length of LSC and separates areas in the east and the west.

The system comprises five NHS trusts, 42 PCNs and four upper-tier local authorities. It faces considerable financial challenges and is rated as 3 in NHS England's outcomes framework. Parts of the population are ethnically diverse and there is widespread deprivation with direct effects on the health of the population.

Recovery and transformation

The ICB is seeking to address these challenges in a recovery and transformation programme. The board's chief executive, Kevin Lavery, says the main aim of programme is to 'get the basics right' in order to stabilise finances and provide the foundations on which 'to move to world class over time'. Immediate priorities are to secure agreement on streamlining the provision of hospital services by reducing duplication and fragmentation of clinical and support services, recognising that this will not be easy.

Kevin adds that there is also a need to 'get a better balance between hospital and community services' and tackle workforce challenges. The latter includes reducing the costs of agency staff, which are contributing to financial challenges in NHS trusts. As a

newcomer to LSC, Kevin observes that leaders in the system must be prepared to be bold and start delivering changes in clinical services that, in his view, are overdue. His plans envisage the ICB having a small, slim, strategic centre with major delegation to the four places that make up the system under a place integration deal.

Improvement work

NHS trusts in LSC have used a range of improvement methods that predate the establishment of the ICB and are at different stages of maturity. Trusts work together and with other partners through the provider collaboration board (PCB), which plays a key role in the system. The PCB is a joint committee of the five NHS trusts, is co-funded by the trusts and also receives support from the ICB. Trusts are able to delegate decision-making on collective projects to this committee.

In 2021, following an external review carried out by NHS improvement expert David Fillingham, who now chairs the Lancashire and South Cumbria NHS Foundation Trust, the PCB agreed to adopt common principles of improvement. This was taken forward under the leadership of Ailsa Brotherton, director of continuous improvement at Lancashire Teaching Hospitals NHS Foundation Trust, and improvement leads drawn from across the system. It includes the development of a system wide quality management system.

The main recommendations in the Fillingham review were:

- the PCB should adopt a structured approach to the development of its shared improvement and transformation activity within the context of the broader developmental support being provided by NHS England
- a task group combining a subset of trust strategy directors, HR/OD directors and improvement leads should be established to carry this work forward

- the development of an operating system should focus on prioritising the large number of short- and longer-term initiatives underway and assess which of these are most suited to the use of improvement methodologies
- the trust improvement leads should be tasked with creating a shared language and set of resources for system-level transformation work, drawing on the Vital Signs and Flow Coaching Academy methodologies
- collaborative leadership development should focus on the understanding and practice of system leadership behaviours
- the place-based partnerships should be engaged in this work at the earliest practicable opportunity.

The PCB subsequently decided to use the Engineering Better Care approach, developed by John Clarkson and colleagues at the University of Cambridge, based on system principles and outlined in a report from the Royal Academy of Engineering and others.[32] Quality improvement leads in the trusts proposed the following principles for system-wide improvement work:

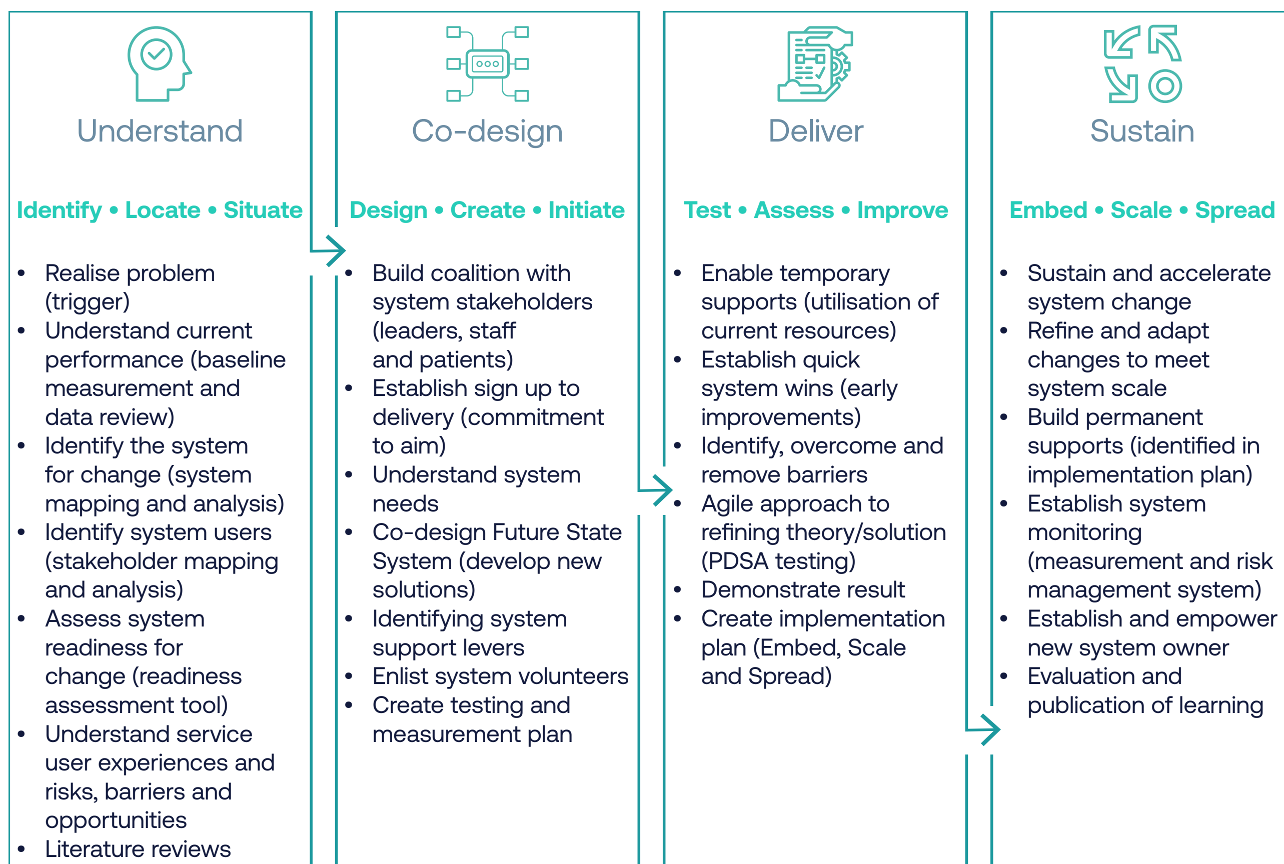
- **Vision and ambition** – Our teams will work together with our clinical and operational teams to create a shared vision for each improvement programme with the aim of levelling all our organisations up to the 'level of the best.'
- **Working together as one team** – As improvement leads we commit to working together on system-level improvement to share our knowledge, expertise and quality improvement resources across our organisations to maximise our successes.
- **Adopting robust improvement science** – We recognise the importance of adopting improvement science methodology to maximise the levels of improvement achieved.
- **Evidence based approaches** – We commit to ensuring each improvement programme commences with a review of the evidence, looking outwards to learn from others and where possible designing our improvement to meet clinical standards.
- **Measuring and monitoring our impact** – Each programme will have a clear measurement strategy and plan to ensure

impact and outcomes can be tracked over time and reported to the PCB.
- **Values driven** – We commit to working in line with our organisations' and ICS values.

Throughout this work there was an emphasis on organisation development, leadership, relationship building and creating a well-connected network of people skilled in improvement. Work was also informed by the experience of those involved and familiarity with the evidence on improvement approaches and literature published by the Health Foundation and others. Training in Engineering Better Care methods was put in place for staff across LSC.

The steering group set up to oversee the work includes a think tank to share learning and develop a bespoke Engineering Better Care approach across Lancashire and South Cumbria, and a 'do tank' to develop leadership with system partners and lead work on improvement.

The following diagram summarises the approach:



Examples of improvement

Kevin McGee, chief executive of Lancashire Teaching Hospitals NHS Foundation Trust and leader of the PCB at the time of the interview, argues that the strong foundations of improvement work in some NHS trusts facilitated the spread of this work into system-wide issues. His experience at East Lancashire Hospitals and Lancashire Teaching Hospitals has convinced him of the ‘huge positive difference’ that quality improvement can make in embedding high standards of care in hospitals and other settings. He cites work on Vital Signs and the Flow Coaching Academy as examples.

An early priority for system-wide work on improvement was frailty. This encompasses a shared definition of frailty, frailty assessment

tools, a more standardised approach to provision of care depending on the level of frailty, a shared approach to anticipatory care planning, a shared approach to co-production and a shared measurement strategy and plan. Metrics being used to assess impact include calls to the ambulance service, attendances at emergency departments and hospital admissions, and lengths of stay for patients who are admitted.

A recent review of the Engineering Better Care work on frailty reported progress to the PCB and identified several risks to the programme. These include the capacity of teams to contribute in the face of huge operational pressures and industrial action, and system-level barriers related to IT and interoperability. The time needed to show results in relation to the urgency of operational pressures is also a risk.

Other system-wide issues that have received attention are elective recovery and cancer care. On elective recovery, the trusts agreed a joint approach to PTL (patient tracking list) management with the aim of equalising waiting times across LSC. This involved enabling patients to be treated in hospitals with short waits and staff working flexibly at different sites to deliver improvements in access. Patients with suspected cancer were informed rapidly if cancer was not diagnosed, to reduce anxiety and concentrate resources on those who needed treatment.

Kevin McGee emphasises that the application of system-wide work needs to be sensitive to the needs and resources of each of the four places that make up LSC and adapted to these needs.

Work is now underway on tackling inequalities in cancer care and outcomes. This is a priority in a system with high levels of deprivation and relatively poor outcomes. LSC is working on this in an NHSE/IHI accelerator programme. As part of the national CORE20PLUS5 programme, LSC has set a target of 75 per cent of the population accessing service with stage 1 and 2 cancers.

The population health focus of this work resonates with priorities of colleagues in general practice and in local authority public health departments. This approach is being embedded more widely through the Population Health and Health Equity Leadership Academy, as highlighted in the Hewitt review. System leaders recognise the value of these partners' contribution and the need to ensure they are fully engaged.

Andy Knox, local GP and associate medical director for the ICB, who leads work on population health improvement, explained that each primary care network is undertaking a project to tackle health inequalities. This work is seeking to build capabilities for improvement using data to generate insights and actionable interventions in line with 'hexagon model' illustrated below. This includes creating health with communities by understanding their needs and listening to people to learn what interventions are likely to be most effective.

Enabling capabilities

Emerging lessons

The relationship between work on recovery and transformation on the one hand and work on improvement on the other, is evolving in LSC. Kevin McGee feels the two need not conflict as long as the pressures to take out costs in year do not compromise the investment needed to embed improvement work and its potential to transform health and care in the long term. The approach taken by NHS England as well as that of system leaders is likely to influence how this plays out.

David Levy, medical director of the ICB, argues that there is a need to ensure better coordination of clinical networks of different kinds, national improvement programmes, and work within LSC on improvement. One proposal under discussion is that an improvement hub should be established, led by the ICB working in partnership with the provider collaborative. This would ensure more effective alignment of different programmes with the aim of increasing impact.

Levy and Lavery believe that an urgent priority is to seek agreement in a number of fragile specialties where there are challenges in sustaining services on all existing sites. Levy argues that the aim should be to 'localise where possible and centralise where necessary', with clinicians and managers taking the lead in considering options and the ICB as commissioner being responsible for decisions on sustainability. This includes exploring the use of a lead provider model for these services, which include orthotics, chemotherapy and urology specialist cancer surgery.

Reflecting on progress to date, system and organisational leaders acknowledge that difficult and contested decisions lie ahead and are hopeful that experience of quality improvement work across LSC will provide a strong foundation on which to build. The priority is to continue strengthening leadership and relationships and to extend engagement to a wider range of partners in different sectors. As this happens, it will be important to recognise the inherent complexity of seeking to improve care and outcomes across the system.

Case study four: Dorset – a vision to make Dorset the healthiest place to live

Dorset ICS serves 800,000 people across 1,024 square miles with an NHS budget of £1.6 billion. It includes Bournemouth, Christchurch, Dorchester, Poole, Weymouth and the surrounding rural areas.

Services are provided by three NHS foundation trusts, 18 primary care networks, and two upper tier local authorities. Dorset works through two place-based partnerships in the east and the west of the county, each aligned with the two upper tier local authorities. The system is rated as 2 in NHS England's outcomes framework.

The system's vision is set out in its joint forward plan 2023-28: Making Dorset the Healthiest Place to Live. The plan outlines five outcomes that were agreed at a workshop with system partners:

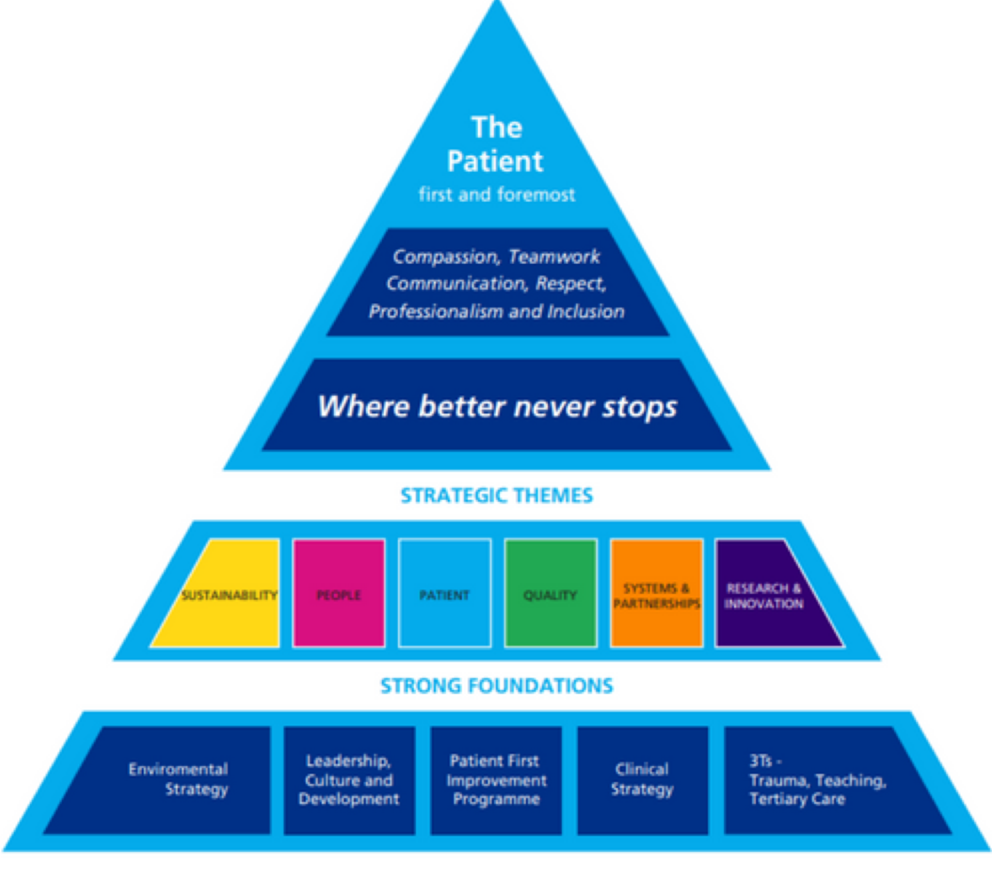
1. We will improve the lives of 100,000 people impacted by poor mental health.
2. We will save 55,000 children from being overweight by 2040.
3. We will reduce the gap in healthy life expectancy for our most deprived populations from 19 years to 15 years by 2043.
4. We will increase the percentage of older people living well and independently in Dorset.
5. We will add 100,000 healthy life years to the people of Dorset by 2033.

These outcomes are aligned with three key priorities in the integrated care partnership's strategy: prevention and early help; thriving communities; and working better together.

Patricia Miller, chief executive of the ICB, emphasised the role of voluntary and community sector organisations in working with statutory bodies to deliver these priorities and the importance of tackling inequalities in health, especially in coastal and rural communities. The priority given to older people reflects their importance in the population and the opportunity to support these people to live and age well. The focus on children and young people will set the foundation for good health in adulthood.

Improvement work

Much quality improvement work is led by NHS trusts with the aim of improving operational performance in hospitals and community services. Various improvement methods have been used in the past and the focus now is on Patient First, introduced to the system by a newly appointed trust chief executive.



The two places will have an agenda much wider than health services. Both will be led by local authorities and will develop plans to support communities to thrive from prevention to palliation, focusing very much on social and economic development as a vehicle for reducing inequalities.

The provider collaborative operates informally, reflecting its recent establishment. The acute NHS trust in the west of the county is working 'as one' with the ICS-wide community and mental health trust, with a joint chief executive and chair. A number of directors work across both boards overseen by a committee in common, with the aim of this partnership becoming the vehicle to deliver the ambition of improved population health and a sustainable provider landscape in the west. The community and mental health trust supports similar work in the more urban place-based partnership in the east.

A major priority in Dorset is to embed a culture of transformation to support delivery of the five pillars in the forward plan. This work is led by Neil Bacon, chief strategy and transformation officer. Appointed in August 2022 and with both a clinical and private sector background, Neil described how he and colleagues have focused on 'changing the thinking' in the system with less emphasis on 'process, meetings and governance' and have worked 'at pace' in doing so.

A major priority in Dorset is to embed a culture of transformation to support delivery of the five pillars in the forward plan.

Their work has concentrated on agreeing smart objectives within the five-year forward plan that are specific and rigorous and can be used to hold system leaders and their partners collectively accountable for performance in improving outcomes. It has been underpinned by data drawn from the Dorset intelligence and insight service (DiiS), which brings together health and social care data from different sources. This data is made widely accessible via interactive and intuitive analytical tools, with the details of over 800,000 patient records updated nightly across Dorset and other feeds updating every 15 minutes.

The development of DiiS was accelerated during the COVID-19 pandemic and became the system-wide reporting tool. It underpins work on population health and system resilience, including Public Health Dorset's epidemiology modelling, and enables analysis at the small area level. This supports targeted interventions in areas of greatest need and assessment of progress in delivering outcomes. DiiS has attracted interest nationally and across the south west.

The outcomes that have been selected in the forward plan require partnership with local authorities, schools, businesses, VCS organisations and, most importantly, local residents, and by their nature will be delivered over the long term. Neil Bacon stressed that it is too early to expect to see measurable improvements in outcomes but examples of changes in ways of working are already apparent.

Examples of improvement

Work on transformation is illustrated by the use of outpatient assessment centres in high street locations in Dorchester and Poole, known as Dorset health villages. As well as increasing available capacity, the centres reduced waiting times and demand for elective surgery and supported patients to enhance their health before surgery in order to improve outcomes. Redesign of the clinical pathway improved patient experience and the working environment for staff.

The main specialties involved are orthopaedics, ophthalmology, dermatology and breast screening. The teams involved have used process mapping to ensure most effective use of the additional capacity. Outpatient assessment centres have contributed to elective recovery in part by supporting the ringfencing of facilities as in the case of arthroplasty.

On health and wellbeing, the Ageing Well programme (featured in the Hewitt review) has halved the number of A&E and emergency admissions among elderly people through anticipatory, preventative care and by integrating community, primary and social care teams at neighbourhood level. The programme includes an at-scale urgent community response service and risk profiling of the community by primary care networks with services tailored to local need. Current work on frailty is building on the programme's success.

In the case of respiratory services, early intervention with people with COPD in rural communities in west Dorset has resulted in reduced hospital admissions and this approach will be rolled out to the rest of the county in coming months.

Emerging lessons

System leaders see the role of the integrated care board as an enabler and catalyst of transformation and do not seek to control how improvement work is done. They recognise that various methods are needed to deliver the system's priorities and that there are challenges in improving outcomes that depend on factors outside their direct control. Local authorities are critical in making progress on population health improvement but face significant financial challenges in meeting the needs of an ageing population.

NHS trust chief executive Matthew Bryant reported that the integrated care board is 'adding immense value and is a powerful convenor', playing a vital role in managing relationships with local authorities and reaching out to the local population in developing its plan and strategy. Looking ahead, his concern is of potential duplication and confusion between the ICB, provider trust boards and NHS England's regional office unless there is clarity on roles and responsibilities. The implementation of the revised NHS England operating framework should provide this clarity going forward.

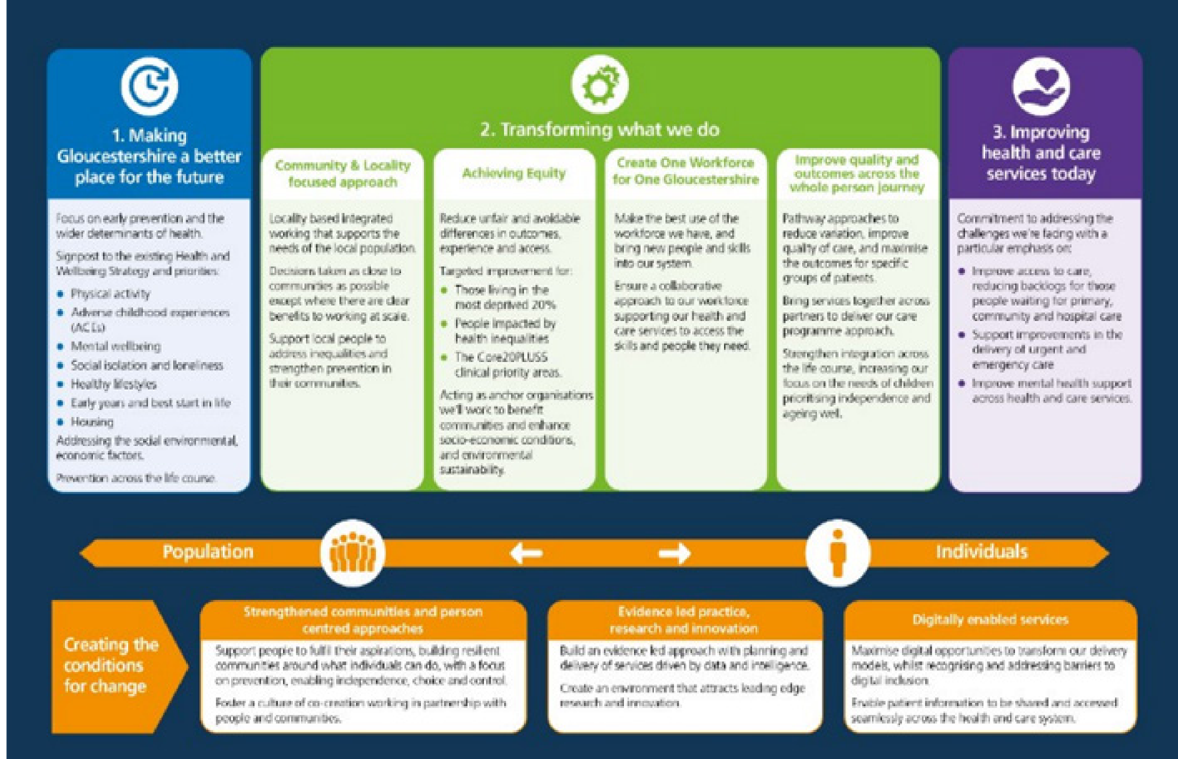
Case study five: Gloucestershire – making a better place for the future

Gloucestershire Integrated Care System serves an estimated 645,000 people, projected to rise to 670,000 by 2025, across 1,220 square miles with an NHS budget of £1.3 billion. It includes Cheltenham, Gloucester, Stroud and surrounding rural areas. Services are provided by two NHS trusts, 15 primary care networks, a county council and six district councils. The system works through integrated locality partnerships (ILPs) aligned with district councils.

The CQC has rated one NHS trust as good and the other as requires improvement. The system is rated as 2 in NHS England's outcomes framework. The population enjoys good health overall, albeit with an 11-year difference in healthy life expectancy between affluent and deprived areas in the county.

The interim integrated care strategy published in December 2022 set out a vision of 'making Gloucestershire the healthiest place to live and work – championing equity in life chances and the best health and care outcomes for all'. The strategy is based on three pillars and three conditions for change drawn from engagement with the public and stakeholders.

Strategy on a page



This diagram is also accessible online:
www.nhsconfed.org/publications/improving-health-and-care-scale

In the early stages, Gloucestershire's work was informed by the experience of the Canterbury District Health Board in New Zealand.

Running through the strategy is a commitment to work in partnership with people and communities in neighbourhoods and localities. Emphasis is placed on the strengths of communities not their deficits. This includes valuing the role of voluntary and community sector organisations as well as local authorities. The strategy sets a direction for the next 15–20 years and recognises the time it will take to realise the vision.

Improvement community

A Gloucestershire improvement community has formed, drawing on work in the former CCG and partner NHS trusts. The legacy of this work, which is one of the foundations of the

One Gloucestershire ICS, includes a growing number of quality improvement specialists developed through the Quality, Service Improvement and Redesign (QSIR) programme and other work.

The improvement community is led by Hein Le Roux, local GP and quality improvement lead for the system, working with Kathryn Hall, associate director for the improvement community. Hein's involvement in the Q community facilitated by the Health Foundation helped shape the approach taken in Gloucestershire. Improvement leads in Gloucestershire's hospitals were instrumental in establishing the delivering improvement network to share ideas and experience with provider-based colleagues from across the country.

... building an improvement community is 20 per cent technical and 80 per cent about people.

Kathryn emphasised that building an improvement community is '20 per cent technical and 80 per cent about people'. Gloucestershire is a relatively small system, and this facilitated relationship building and helped win people over to the One Gloucestershire approach to improvement. A convening session was held to identify the common principles behind the various methods in use to inform the development of this approach.

The stated purpose of the improvement community is 'to extend our collective improvement capability and capacity, and to develop fresh approaches to our shared practice for system improvement'. A playbook has been developed setting out the strategic approach now being put in place, to achieve by 2028 the vision of 'a thriving improvement culture across One Gloucestershire health and care partners'. This is supported by a delivery plan for how this will happen.

Local authorities are involved in the improvement community and social care is a key development priority. District councils are at the heart of the integrated locality partnerships, which is where place-based collaborations contribute to the work of the system. Mary Hutton, chief executive of the ICB, explained that 'collaboration is at the heart of how we deliver better outcomes

and joined-up care for our local communities. Our improvement community has an important role in developing our shared culture of improvement and facilitating our teams to come together with common tools and methodologies.'

Hein and Kathryn explained that the aim is to make quality improvement open and inclusive and to avoid it being perceived as a specialist or elitist activity. An early priority was the engagement of leaders at every level and use of simple, shared language in discussing the work. Leadership is provided by an improvement board chaired by Angela Potter, director of strategy and partnerships at Gloucestershire Health and Care NHS Foundation Trust, and a steering group chaired by Hein. To supplement local expertise, Gloucestershire has recently appointed Newton Europe as a delivery partner in a new urgent and emergency care transformation programme.

An ICS capability assessment tool was used to aid understanding of the maturity of the system (described as 'developing') and gaps that needed to be filled. Investment in training has increased the number of staff with QI skills and was supported by co-teaching by faculty from different organisations and backgrounds and acceptance of there being 'a thriving village of approaches' in different parts of the system. The foundations laid at system level and in NHS trusts were invaluable in creating a receptive context, as was learning from national and regional partners and diversity of skills and experience among local QI experts. Hein highlighted Kathryn's background as an engineer and her skills with people as being vital assets.

Examples of improvement

Three contrasting examples illustrate how health and care services have been improved. The first concerns cancer care, where work that started in 2016 has resulted in a series of improvements in diagnosis, referrals, and streamlining of pathways. The benefits

became apparent during the COVID-19 pandemic when cancer services proved resilient and adaptable in the face of an unprecedented threat. More recent work has involved quality improvement work in PCNs to improve early diagnosis.

The second example is the Warm Home Prescription project. This identified patients with chronic conditions adversely affected by cold homes. With the support of a local energy charity, eligible patients were visited and offered help, including with the costs of heating, using funds provided by the county council. The project enabled patients to remain independent and alleviated pressures on GPs, hospitals and other services. It illustrates the way in which Gloucestershire is beginning to fulfil commitments in its integrated care strategy.

The third example is the use of community-based clinics to follow up COVID-19 patients who required intensive or high-dependency care. A multidisciplinary team adopts a holistic approach to the assessment and care of these people, from acute critical care to community, social prescribing and other contributors to health and wellbeing. The clinic model won the Patient-Centred Care Award of the Intensive Care Society.

Emerging lessons

System leaders emphasised the importance of ICBs being held to account for the use of resources and delivery of results for their populations. They also recognised a risk that top-down performance management might derail efforts to build a culture of learning and improvement. Working closely with NHS England's regional office was essential to avoid this danger and create time and space for improvement work to become embedded.

Case study six: Cambridgeshire and Peterborough – Creating a system of opportunity

Cambridgeshire and Peterborough ICS serves 950,000 people across around 1,442 square miles. It receives an NHS allocation of £1.5 billion and total income of circa £4 billion, reflecting treatment of patients from other areas in the system's hospitals. It is made up of two main population centres in Cambridge and Peterborough and a dispersed population in surrounding rural areas. The system comprises five NHS trusts, 22 primary care networks, two upper tier local authorities and five district councils. It works through two place partnerships in the north and the south.

The ICS has committed to five priorities:

- Reducing health inequalities, illustrated by a ten-year gap in life expectancy between deprived areas in Peterborough and affluent areas in Cambridge.
- Creating a system of opportunity by supporting staff to be the best they can be.
- Giving people more control over their health and wellbeing.
- Delivering world-class services enabled by research and innovation.
- Being environmentally and financially sustainable with a resilient workforce.

The CQC has rated two trusts as outstanding, two as good and one requires improvement. The system is rated 3 in NHS England's outcomes framework.

The system strategy includes three overarching health and wellbeing ambitions: to improve outcomes for children, reduce inequalities in deaths under 75 years, and increase the number of years people live in good health.

Improvement work

Jan Thomas, chief executive of the ICB, explained that the board has an 'enabling function' and does not see its role as 'telling providers what to do'. Each organisation has to adopt an approach appropriate to its needs and circumstances, with the ICB providing an environment in which improvement can flourish.

The board has deliberately kept its staffing 'thin' and delivers system priorities through five accountable business units. Two of these units are centred on places in the north and south and are led by North West Anglia and Cambridge University Hospitals NHS Foundation Trust respectively. The remaining three units lead on mental health, learning disability and autism; children and maternity services; and strategic commissioning. There is no provider collaborative.

Cambridge University Hospitals NHS Foundation Trust serves patients from outside the system as well as local people and collaborates with providers across the east of England in developing specialist services. Within the system it is closely involved in integrating services in the southern place and is involved with partners in the Adopting Innovation Hub, now integrated into the ICS and supported by the Health Foundation. The functions of the hub include a citizen participation group, involving people with lived experience and a passion for improving health and care for the local population.

Gary Howsam, chief clinical improvement officer for the integrated care board, explained that there was considerable experience of quality improvement work in the system but this had been

'siloed historically'. Together with colleagues, he has developed a continuous quality improvement strategy for the system with the aim of moving towards a more consistent and joined-up approach across health and care. A core objective is 'expanding improvement beyond individual organisational functional boundaries'.

The strategy identifies the following success factors:

- Staff who are passionate about the delivery of improving high-quality care for our patients.
- Staff and leaders at all levels across all organisations that are engaged, confident and committed to making improvements.
- Collaborative ways of working with patients and key stakeholders in driving system improvements.
- Clear links from local improvements to our vision, ambitions, and priorities.
- Integrated improvement planning with our strategic, business and performance management planning.
- Sharing opportunities with peers and internal networks to build skills and knowledge transfer.

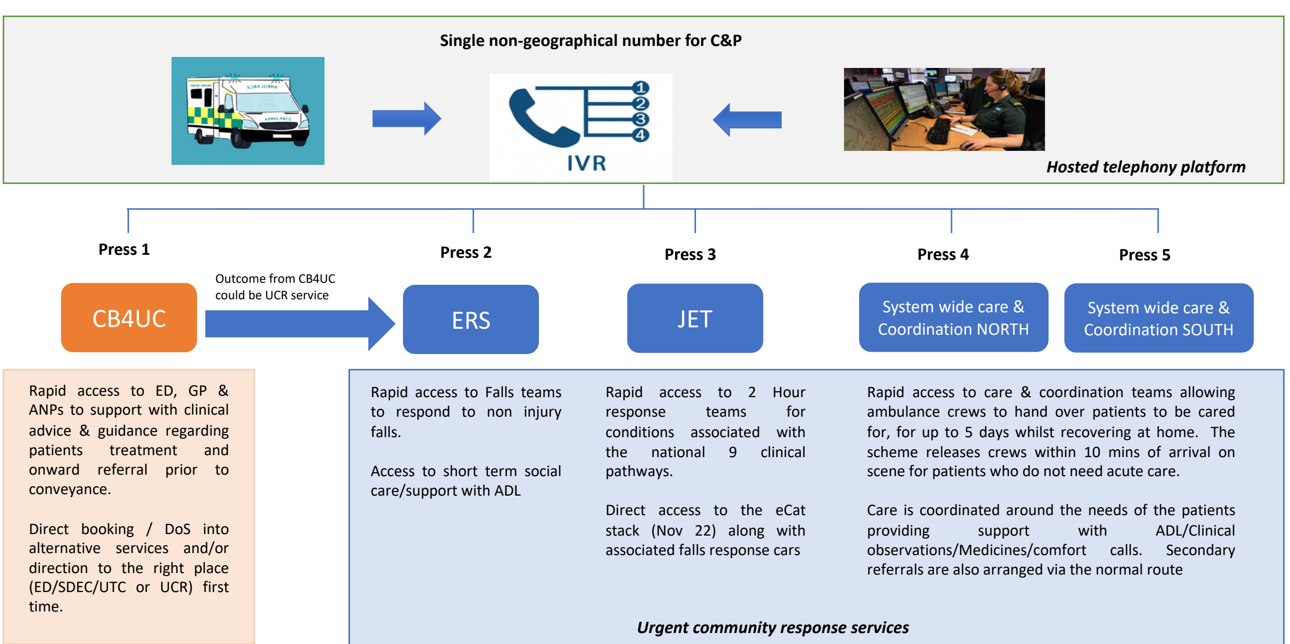
A high priority is to build capacity and capability in using improvement science tools and techniques drawing on the expertise of NHS trusts and other partners. The aim is to 'demystify' QI and adopt a pragmatic approach while avoiding imposing a single methodology. Progress is overseen by the quality improvement and transformation board, chaired by Greg Lane, ICB director of clinical improvement, which has been meeting monthly for 18 months.

As a local GP, Gary is keen to involve general practices that have not had the same access to training and support as staff working in NHS trusts. Primary care networks are at varying stages of maturity and are working with the ICB and other partners to develop integrated neighbourhood teams to better understand and respond to local health and care needs.

Example of improvement

An example of how the strategy is being deployed is the 'call before you convey' service. Launched in November 2022, and drawing on experience in Oxford, the service offers ambulance crews advice and support as they attend people in the community. In addition to being a single point of access, call before you convey can book directly into other services, including new wraparound services that provide at-home care for up to five days, dedicated falls response vehicles 24/7, and extended urgent community response services.

Call before convey – single point of access



Key: ERS (Emergency Response Service) JET (Joint Emergency Team) GPN (Greater Peterborough Network GP Federation)

Since its launch, the service has supported 4,241 people, enabling over 75 per cent to be supported at home or in an alternative to emergency department services, releasing time for ambulance crews to attend life-threatening cases. Admissions avoided through extended urgent community response services and new wraparound care has also contributed to a reduction in attendances, admissions and waiting times across urgent and emergency care services.

Emerging lessons

Jan Thomas reflected that a challenge for the ICB had been to demonstrate to partners that its role was not to be prescriptive. Instead of focusing on improvement methods, system leaders had concentrated on bringing about changes in culture and relationships. This included valuing learning, fostering collaborative behaviours, sharing of expertise and improvements in care, and seeing frontline staff as change agents.

Work that started before the establishment of the ICB had laid the foundations, and the appointment of a chief clinical improvement officer signified the importance attached to clinical engagement and leadership in the system. Those involved recognise that they are at an early stage of the journey and time is needed to leave old behaviours behind and embrace ways of working to enable the system to become the best that it can be.

Leaders within the system acknowledge the challenges in making progress on issues of concern to the population of Cambridgeshire and Peterborough and the role of Cambridgeshire University Hospitals NHS Foundation Trust across the east of England and beyond. The biomedical campus in Cambridge and the presence of life sciences companies are important assets for local people, as is the ability to attract external support, for example in the Adopting Innovations Hub. Integration of services in the southern place is dependent on the trust being fully engaged in this work.

Case study seven: Thames Valley and Surrey – Sharing care records

This programme is a collaboration between three ICSs: Frimley Health and Care; Buckinghamshire, Oxfordshire and Berkshire; and Surrey Heartlands and East Surrey. These systems serve a combined population of 4.2 million served by 12 NHS trusts, 335 general practices, three county councils, six unitary authorities and 14 district and borough councils.

The programme's principal focus is on ensuring that health and care professionals involved in a person's care have safe and secure access in near real-time to a comprehensive care record and that care plans have been linked. A key aim is that citizens and carers are empowered to manage their own care through having access to their own health and care records. A further ambition is to use patient data to improve population health and to support research where appropriate.[33]

The work is led by Jane Hogg, formerly transformation director at Frimley Health and Care and now senior responsible officer for the Thames Valley and Surrey Shared Care Records (TVS SCR) partnership programme. Jane explained that the work originated in 2018 following a successful bid to the Local Health and Care Record Exemplars Programme set up by the Local Government Association and NHS England to support data sharing and to promote the use of data to improve health and care. The bid attracted national funding and support in relation to information governance and related issues.

The programme is hosted by Frimley Health NHS Foundation Trust on behalf of the three systems involved. It is underpinned

by a partnership agreement between these systems and the host organisation. A shared care record board chaired by Fiona Edwards, one of the system chief executives, oversees delivery. Jane leads a small team and explained that most of the work is done locally by staff with relevant expertise. The programme is ‘agnostic about improvement methods’ and emphasises the common principles required to underpin improvement.

Thames Valley and Surrey was part of Combined Intelligence for Population Health Action (CIPHA) for a time and this helped facilitate progress across a larger number of ICSs. The involvement of three ICSs offers the potential of testing different approaches in different areas and sharing worthwhile interventions and innovations when they have been identified.

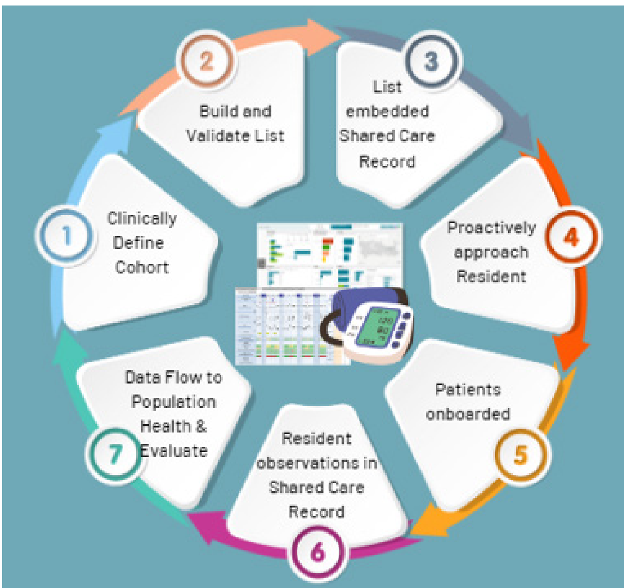
There is a strong focus on health outcomes and the actions that might improve them. This is underpinned by use of data from the shared care record (known as Connected Care in the Frimley system, the most mature to date) to understand variations in outcomes and track how they change as a result of interventions.

In the case of Frimley Health and Care, work has focused on the CORE20PLUS5 population including the health needs of people living in multigenerational housing. Interventions entail raising awareness in health and care teams of these needs and making referrals to housing and benefits advice, fuel vouchers and citizens’ advice.

Another priority has been to improve the management of high blood pressure using data on the performance of general practices. By focusing on this issue and engaging general practices, the gap between affluent and deprived areas has narrowed and more people with undiagnosed hypertension have been identified.

A further example is the use of remote monitoring technology, which has been rolled out at pace across the Frimley system. Over

5,000 patients, including care homes residents and high-risk patients with long-term conditions, have been enrolled on the platform so far. This has only been possible because of the insight generated by the TVS SCR platform and the ability to build intelligent patient cohorts to identify which members of the population would most benefit from remote monitoring support. Patients are enrolled through a platform that enables monitoring through two remote monitoring hubs – a significant evolution of the work started during the COVID-19 pandemic to monitor patients using pulse oximetry.



The team has identified the following factors required for success:

- Working with local networks of clinicians and clinical leaders.
- Using skilled analysts and those with change skills.
- Having a mature (but not necessarily complete) linked data set, to draw the insights.
- Building support among the leadership of the value and opportunity.
- Focusing on population health principles and making a difference through 'intelligence' alongside expertise.

These principles are being applied in the Waiting Well programme to support patients waiting for elective surgery. Joint work between acute hospitals, general practices and the ICB is currently seeking to design new same-day access models for patients.

In this example and others, the team emphasised that progress hinges on changing working practices and cultures to shift from a reactive to a proactive approach. As in all improvement activities, this means working closely with staff 'doing the work' – such as in general practices – and supporting them with data and evidence of what works. The involvement of senior leaders is also vital to signal the priority attached to the programme.

Emerging lessons

A number of challenges have been encountered, including the legacy of competition between NHS trusts and sustaining progress when some partners may prefer to pursue their own data-sharing solutions. The partnership agreement has been framed in a way that reduces risks to other partners should one choose to leave. The team leading the work seeks to ensure that concerns are addressed as they arise to keep everyone 'in the tent.' With national funding having been exhausted, ongoing costs are now shared by the organisations involved, which is an indication of the value they attach to it.

System leaders feel that the principles of the programme could be adapted for use on other issues and gave temporary staffing as an example of where there is already interest in work across the three systems. An NHS trust adjacent to these systems has joined the programme because of patient flows into and out of its services indicating the possibility of extending the collaboration. System leaders in Frimley have been actively working more with other systems in the south east (and at times, further afield) to explore other possibilities for working together at scale.

Case study eight: Surrey Heartlands – One system, one plan

Surrey Heartlands Health and Care Partnership serves a population of around 1.1 million people across 552 square miles with an NHS budget of £1.5 billion. The partnership comprises six NHS trusts, two social enterprises, 25 primary care networks, and 104 general practices, Surrey County Council and 11 district and borough councils. Partners take collective responsibility for improving the health of the local population, managing resources (including money) and delivering high-quality health and social care.

The health of the population is among the best in England, albeit with a 12-year gap in life expectancy depending on where people live. The quality of health and care services is generally high, with most providers rated as good or outstanding. The system is rated as 2 in NHS England's outcomes framework.

The integrated care strategy sets out a range of ambitions on prevention and keeping people well, delivering care differently, and what is needed to deliver these ambitions including workforce, finance and estates. Five critical priorities are identified in the joint forward plan to support delivery of these ambitions. Close working between the NHS and the county council is helping in the delivery of these priorities.

> ... this is about promoting the right partnerships at system, place and neighbourhood level that will lead to improvements in health and wellbeing.

The Surrey Heartlands joint forward plan sets out how the system will support the people of Surrey Heartlands to live healthier lives. There are significant financial challenges as the partnership works together to deliver financial sustainability, transformation and to integrate the delivery model. Building on existing collaboration, this is about promoting the right partnerships at system, place and

neighbourhood level that will lead to improvements in health and wellbeing. The system strategy is summarised in a plan on a page as One System, One Plan (see figure).

The strategy and plan are being delivered in neighbourhoods, the four places that make up the system, and across the system as a whole, for example through the provider collaborative being established between three acute trusts and one mental health trust. These trusts have well-established quality improvement programmes, illustrated by Surrey and Sussex Healthcare NHS Foundation Trust which was part of the Virginia Mason improvement partnership and was rated outstanding by the CQC.

There is a vibrant community and voluntary sector comprising over 1,000 diverse organisations.

One System, One Plan

Under the leadership of Claire Fuller, chief executive of the ICB, the system has given priority since its inception to developing clinical leaders and supporting them to lead improvement work. This includes widening out development programmes to the community and voluntary sector who, as Claire points out, 'also have a major role to play in supporting the prevention agenda and how we transform the provision of care.' Currently the focus is on developing health and care multi-professional leadership and strengthening pathways across health and social care, for example through the Surrey Heartlands Health and Social Care Academy.

As Claire explained: "One of the original building blocks of the Surrey Heartlands ICS was the development of a system-wide academy to support clinicians and the wider professional workforce to adopt, share and evaluate innovation, research and best practice, and was one of our system's original USPs." The academy worked in partnership with Health Innovation Kent Surrey and Sussex, with work centred around clinical leadership, citizen and professional engagement, knowledge management, quality improvement, innovation and research, and commercial development.

A product of the academy, the Surrey 500 was launched in 2019 with a view to offering 500 staff from health, public services and the voluntary sector the opportunity to participate in a leadership development programme. Participants formed strong networks while developing the skills to embed and sustain new ways of working. Once individuals completed the programme, they became part of the Surrey 500 Alumni; a network of peer and specialist collaborative support. The aim was that through the Surrey 500 they continue to develop, stay connected and be supported to manage change. This programme has been relaunched as the Growing System Leaders Programme and is on its next cohort of system leaders.

Clare Stone, chief nursing officer and executive director for multi-professional leadership, explained that the system has chosen 'to go with the grain' of established quality improvement approaches and does not seek to impose or prescribe a single method, but brings people together under a single framework to collectively drive change. A quality improvement collaborative drawn from partner organisations across health and care provides a focus for much of the work that is taking place. Clare observed that this was slow to get going but is now beginning to play a more active part in improvement work.

The collaborative has been involved in developing a quality management system (QMS) for Surrey based on common principles and aligned with the thinking of the National Improvement Board, the response to the Hewitt review and the NHS IMPACT requirements. The Health Foundation is supporting work applying the QMS and on the leadership behaviours needed to embed improvement in the system.

System leaders plan to apply the QMS to issues identified as priorities in the integrated care strategy and the joint forward plan. This might involve working though the provider collaborative or the place partnerships that lead efforts to integrate care in different parts of the system, typically for populations of between 250,000

and 300,000. Local authorities, as well as voluntary and community sector organisations, are at the heart of these efforts, which include local action on the Fuller stocktake.

Examples of improvement

The East Surrey Alliance, one of the four Surrey Heartlands' Place Partnerships, is bringing partners across the local system together to make a step change in discharge planning, dramatically transforming the experience of patients. Their approach involves working with the Virginia Mason Institute to create sustainable change through a much more integrated model across health and social care. Key elements to the programme include:

- critically evaluating the current state, mapping existing processes and how patients flow through the local system
- identifying waste across all care settings, its impact on workforce capacity and how this contributes to delayed discharges across all Discharge 2 Assess pathways
- patient and carer involvement as a fundamental element of the planning process
- detailed demand and capacity planning
- a fundamental review of how care packages are commissioned during and after a hospital admission to ensure continuity of care.

Another example at the neighbourhood level is a health creation approach on a housing estate in Merstham. This involved GPs listening to people living on the estate about what matters to them and working with a range of partners to find solutions. These solutions included setting up a mother and baby group, providing help with housing, and starting a gardening scheme. One of the GPs involved has described the approach as 'start small and build big' in work which has similarities with the population health programmes in Lancashire and South Cumbria described above.

Emerging lessons

System leaders understand the urgency of moving to the delivery of tangible change. Clare Stone noted that 'there is no blueprint for any of this', which can be a source of anxiety but also creates opportunities to develop a strategy that works for Surrey Heartlands. A number of challenges are being addressed. They include ensuring that competing priorities do not delay the momentum that has started to build and the concern among some partners that they will be 'done to' by the ICB.

There is recognition that to date there has historically been too much focus on medical leadership and this is being tackled through the commitment to multi-professional approaches and applying the findings from a system peer review. The establishment of the provider collaborative, considerably later than in some other systems in this report, and the growing focus of place partnerships is a sign of where effort is now being focused.

Learning from other sectors

Healthcare Improvement Scotland (HIS)

HIS has worked for over 12 years on the improvement, redesign and transformation of health and care services. It connects policy and legislation with the delivery of health and social care. Multidisciplinary redesign and improvement teams support NHS boards, integration joint boards and their partners to make things better for people in Scotland who need health and social care services.

These teams harness specialist skills in quality improvement, service design, strategic planning, change management, clinical leadership, lived experience and other areas. Their work is informed by a set of values:

- Lived and living experience are at the heart of everything that is done.
- Evidence about what works underpins improvement, redesign and transformation.
- Health and social care is a complex system which requires a whole-system approach.
- Transformational change must get to the heart of the changes needed.
- Complexity must be embraced to make effective change happen.
- A culture of continuous learning and reflection is needed to build capacity in the system.

The HIS quality management system reflects these values, which underpin all work programmes.

The work of HIS includes developing and facilitating learning systems by sharing of practice and innovation and providing opportunities for people to work and learn together in collaboratives and other programmes. It currently facilitates 15 national learning systems covering areas such as dementia, patient safety, improving access, and mental health and substance use. HIS uses a multi-method approach to improvement, recognising the importance of matching the approach to the issue being addressed. This multi-method approach is built on a foundation that draws from the work of IHI, including the use of the model for improvement for implementing change. It notes it has the benefit of being flexible enough to be applied in a wide variety of contexts, from discrete process improvement work in clinical teams through to supporting implementation within the context of large-scale system transformation.

Improvement programmes include four key phases: understanding the issues in the service concerned; designing improvements for testing; implementing and evaluating these improvements; embedding and spreading improvements to other areas and services. A recent example was a programme on new models of hospital at home.

Ruth Glassborow, who was director of improvement at the time of interview, explained that part of HIS's work includes working with providers to develop solutions to common quality problems, and having done so to support spread and implementation across Scotland. An example is its work on frailty. In some cases, sprint methods are deployed to test and develop rapid improvement, as in work to improve access in primary care which uses a seven-week sprint.

Most of HIS's improvement work is 'pulled in' by NHS boards and integration joint boards rather than being pushed out by HIS. Even with approximately 170 improvement staff, HIS has finite capacity and this can result in 'healthy competition' from boards to take part in its programmes. Participation draws heavily on clinicians and managers in health and care and people with lived and living experience. An example of the latter was work to develop new models for learning disability day support.

HIS emphasises that improvement should be based on commitment and not compliance. Bespoke support is sometimes offered to providers where inspection visits have highlighted significant challenges that would benefit from external improvement input and in this context there is an expectation that support will be taken up. In providing this support, HIS works with and alongside staff in a respectful manner recognising that challenged organisations include good practices relevant to others.

HIS emphasises that improvement should be based on commitment and not compliance.

Work on patient safety dates back to 2008 and has benefited from strong and consistent multi-party political support and a clear improvement method. It includes an acute improvement

programme in which HIS has supported 14 NHS boards to deliver measurable improvements in areas such as reductions in pressure ulcers, falls and cardiac arrest rates. In this as in other work, learning drives everything that is done, which can be at odds with accountability measures placed on organisations.

Based on its experience, HIS has distilled a number of lessons on the key components needed to support large-scale change. These relate to the IHI's experience that sees improvement as requiring alignment of the will to make change, ideas about what to change, and the ability to implement changes. Learning from the Scottish Patient Safety Programme and national programmes run by HIS suggest that lack of will to make change and the ability to implement change are usually the key barriers. The former is often due to leaders trying to spread top-down solutions to problems people may not even know they have.

Progress can be made where it is inclusive of people who use the service and those who deliver it.

Progress can be made where it is inclusive of people who use the service and those who deliver it. Time must be taken to ensure ownership of both the problem and the solutions through techniques such as user research and process mapping to expose how crazy the design of the current system is and co-designing change ideas. HIS has learned that it is important to celebrate successes and blend stories and data to build the will to change. Logic models and driver diagrams have demonstrated their value, ensuring evidence-informed design of improvements, as have multidisciplinary change teams with the skills and time to do the work. In all cases, adapting changes to local context is essential.

Ruth reported that several ICSs in England have been in contact to learn about the work of HIS as they develop their improvement programmes. It identified a number of challenges based on experience:

- Capacity and capability in QI skills in health and social care had been lost to some degree during the COVID-19 pandemic because of staff turnover, illness and other factors.

- It is essential to keep reiterating that improvement work is relational and not just technical and as such, time is required to build relationships and networks.
- There can be tensions between improvement work and performance management when the latter entails a command-and-control approach and results in behaviours that run counter to those needed to engage local leaders and staff delivering care.

Sector-led improvement in local government

Sector-led improvement (SLI) has been a feature of local government for many years but became more important with the abolition of the Audit Commission, announced in 2010 and completed in 2015. Sarah Pickup, deputy chief executive of the Local Government Association (LGA), explained that it arose from a concern to avoid top-down performance management and for the local government sector to draw on its strengths and experience to support improvement in the work of local authorities.

As described by the LGA:

'SLI takes the view that the responsibility for improvement in local government should stay with councils and is underpinned by the following key principles:

- Councils are responsible for their own performance and improvement.
- Councils are primarily accountable to local communities.
- Councils have a collective responsibility for the performance of the sector as a whole.
- The role of the LGA is to maintain an overview of performance of the sector and to provide tools and support'.[34]

The cornerstone of SLI is peer support and challenge. Peer support often involves mentoring for new leaders, or new cabinet members

or new chief executives. Peer challenge involves councils being visited by teams of peers – both elected members and officers – who spend up to five days in these councils. The focus may be generic or 'corporate', to use the LGA's language, reviewing how the council as a whole is performing, or 'bespoke' to particular challenges where specific support is needed, for example on finance or children's services. Participation is voluntary but is 'heavily encouraged' for all councils.

Visits are intensive and Sarah Pickup explained that they bring benefits for the councils who request them and participants in the teams involved. The LGA has found willing support within the sector for people to be released to undertake the work. The credibility of peer support and challenge derives from the experience of those undertaking it in relation to the issues under review and requires advance planning to ensure availability. Participants in visiting teams receive a day's training in preparation for visits, with elected members being reimbursed using standard day rates and officers giving their time pro bono.

Alongside peer support and challenge, SLI works to build leadership capacity, helps councils improve efficiency and productivity, and supports greater devolution and the development of strong local economies. The main grant funding for SLI from the Department for Levelling Up, Housing and Communities amounts to £18 million in 23/24. In addition, there is funding of around £7 million from contracts with the Department of Health and Social Care and some further smaller amounts of funding from other government departments. The National Audit Office estimated in 2010 that the cost of the previous national regulation framework was in excess of £2 billion, suggesting that it is 'extremely good value for money compared with the predecessor framework' (ibid).

An independent evaluation of SLI published in 2019 provides more detail on how it works and reports the views of local government leaders who have taken part.[35] Sarah Pickup is clear that SLI can be used in the NHS notwithstanding an established performance

management system. Her view is that it can facilitate peer-to-peer shared learning and is particularly relevant to the work of ICSs.

The LGA is now working with the NHS Confederation and NHS Providers to take forward learning from SLI in the Leading Integration Peer Support Programme (LIPS). An example of how it is being used is in the development of a local framework for clinical and care professional leadership in Gloucestershire, which included a peer review in March 2022. The review helped leaders in Gloucestershire reshape its traditional clinical council into a wider-reaching clinical and care professionals council.

The Leading Integration Peer Support Programme: Using peer review to strengthen clinical and care professional leadership arrangements within Gloucestershire

When developing its local framework for clinical and care professional leadership, Gloucestershire integrated care system (One Gloucestershire ICS) wanted to take an approach that explored opportunities to strengthen leadership in an inclusive way. An external peer review, facilitated by the Leading Integration Peer Support (LIPS) programme, created an opportunity for everyone's voice to be heard.

Key benefits and outcomes

- The peer review provided useful intelligence for the local framework for clinical and care professional leadership and the accompanying action plan.
- One Gloucestershire ICS achieved a measurable, deliverable action plan, split into 20 actions that are being taken forward in the short, medium and long term.
- There was improved understanding of the respective roles across the system.
- The peer review gave One Gloucestershire the impetus to reshape its traditional Clinical Council into a wider reaching Clinical and Care Professional Council.
- Having different partners around the table allowed the ICS to explore innovation in a safe space.

Find out more.

Improving Adult Care Together (IMPACT)

IMPACT is the UK centre for implementing evidence in adult social care. It is based at the University of Birmingham and is a broadly based collaboration of partners working in adult social care and in universities across the UK. IMPACT was established in 2021 and is funded jointly by the Economic and Social Research Council and the Health Foundation, with a grant of £15 million that runs until the end of 2027. It should not be confused with NHS IMPACT.

The director of IMPACT, Jon Glasby, based in Birmingham, explained that it operates as 'an implementation centre and not a research centre'. He described its work as 'learning by doing', involving testing out different approaches to the use of evidence and how it can best change practice. This includes working with and alongside practitioners in adult social care and people who draw on care and support on a wide range of projects and in so doing to build capacity and capabilities in using evidence and enabling change.

Following an initial co-design phase in 2021, IMPACT moved to establishment in 2022 and is now involved in delivery of its programmes. Delivery entails using staff in hybrid roles who can bridge research and practice and also contribute facilitation and OD skills. Evidence encompasses academic research resulting from evaluations, practice knowledge based on experience of delivering adult social care, and the lived experience of people who draw on care and support or who are unpaid carers.

A national survey and in-depth consultation and engagement during the co-design phase captured the views of a range of stakeholders on what they wanted from IMPACT and was influential in shaping its modus operandi.

Jon Glasby emphasised the challenges of working in a large and fragmented sector comprising public, private and voluntary sector providers where competition can be more prevalent than

collaboration. It is for this reason that IMPACT seeks to work on common problems and solutions. The co-design phase included reaching out to organisations in Sweden and the Netherlands for learning about how best to bring about change. They are now part of a broader 'critical friends' group, which provides insights and challenge from outside UK social care.

IMPACT'S theory of change reflects the specific characteristics of the adult social care sector and its work is organised into four delivery models:

- **Demonstrators** explore how we can use evidence to address a major strategic issue and are co-produced with local stakeholders. Demonstrator coaches work with local people, and draw on evidence, to understand the issue and how it can be addressed, before facilitating an evidence-informed change programme.
- **Networks** are made up of a series of local groups across the UK, each comprising eight to ten people who meet to discuss a common yet complex challenge using a set of pre-prepared materials. Each local group meets regularly over a period of six months to work on practical actions locally, with their experiences and learning collated by the central IMPACT team and shared back out with network members before their next meeting.
- **Facilitators** work within a local organisation leading a more bounded, bottom-up evidence-informed change project. Through close collaboration, facilitators review evidence, lead local change and evaluate in order to share learnings and outcomes for replication across the sector.
- **Ask IMPACT** aims to be a trusted repository of practical guides, based on existing evidence, in response to challenges the sector is facing, and is a service provided by the University of Birmingham's Knowledge and Evidence Service. The underpinning methodology aims to be transparent and rigorous, while also producing material that is accessible and practical.

With all delivery models, the aim is to provide practical support in the reality of local services and of people's lives, but also to embed key lessons in national policy and practice across each of the four nations.

A wide range of pilots were undertaken in 2022-23 including asset-based approaches to support for older people, a demonstrator in Northern Ireland, the use of technology in home care, a facilitator in Scotland, support for carers of people with dementia at the end of life, a facilitator in Wales, and value-based recruitment via a network. New projects in 2023 encompass managing waiting lists, tackling loneliness in rural areas, people with learning disabilities and autism coming out of hospitals, and hospital discharge. Each project is underpinned by a local theory of change to reflect the context in which it is operating, and future plans to influence national policy and practice.

The work of IMPACT is being evaluated both internally and externally via SQW, a national research consultancy.

Drawing out lessons

Emerging themes

Each system has charted its own improvement course based on local context and the views of system and other leaders. Shared leadership of improvement is being developed and system leaders describe themselves as convenors and enablers of improvement. Some make a point that their job is not to prescribe how improvement should be done.

The convening role of systems includes facilitating conversations, building and strengthening relationships, and creating an improvement community drawing on expertise in partner organisations. Leaders emphasise the need for wide engagement across and within partners with a particular focus on clinical leadership of improvement work – 'unleashing the front line' – and involvement of people with lived experience. The role of leaders who build networks and trust among partners is highly valued.

System strategies and plans set out a range of goals, jointly developed with partners, among which improving population health is a universal aim. ICBs are working with provider collaboratives (usually horizontal), place partnerships (typically horizontal and vertical), and neighbourhoods in delivering their goals. Provider collaboratives are at different stages of development and are more salient in some systems than others. A survey by the NHS Confederation and NHS Providers[36] found that collaboratives needed staffing, resources and leadership capacity to succeed.

There is some tension about the respective roles of ICBs, provider collaboratives and NHS trusts in leading improvement and how their work is best aligned. At one extreme, an experienced NHS trust chief executive in one of the case study systems felt strongly that responsibility for improvement should be devolved to provider collaboratives and NHS trusts and should not be run from what she described as 'ICB HQ'. NHS trust chief executives in other systems were less critical of ICBs but shared the view that providers had a major part to play.

Trusts providing specialist services face tensions in balancing work in the systems in which they are located and collaborating with providers in other systems. Both forms of collaboration are recognised as important and they make demands on the time and resources of the staff and organisations involved. Leaders of NHS trusts in this position have a role in ensuring that work in their own systems is not crowded out by work in cultivating relationships across broader footprints.

Our case studies illustrate how different systems are collaborating with partners to build capability and capacity to undertake improvement at scale. They have also been navigating their roles in overseeing performance and enabling transformational change and the tension between them. We have seen how working at scale includes ICSs facilitating improvement in the system, identifying areas in which the system itself can lead improvement with partners, and focusing on improvement of the system.

In carrying out these functions, system leaders are learning how they can add value to the work of partners. This includes supporting work in neighbourhoods, delegating responsibilities to place partnerships, valuing the work of providers, and recognising the contribution of provider collaboratives. It may also entail working with other systems, as in the Thames Valley case study on the shared care record.

To use an analogy, system leaders find themselves in the role of conductors of the orchestra, seeking to bring the best out of the players and not taking on roles better performed by others. This requires different leadership skills and practices than those found in the NHS in the past with a focus on distributed leadership. System leaders are 'learning by doing' as they seek to bring about improvement through influence and persuasion and build shared commitment to change.

> "… system leaders find themselves in the role of conductors of the orchestra, seeking to bring the best out of the players and not taking on roles better performed by others."

All systems recognise the time it takes to work in this way and demonstrate progress and results. This reflects the complexity of improvement work, particularly when it involves many organisations and communities, and to move beyond old behaviours that may act as barriers to change. Releasing time to do the work, especially the time of clinicians and frontline staff, has been particularly challenging in the face of operational pressures, industrial action and staff shortages.

Partnership working is further developed in some systems than others. It can be facilitated by the use of joint appointments, as in Wakefield where the accountable officer for the place partnership is also corporate director for adults and health for Wakefield Council and executive director of community services for Mid Yorkshire NHS Trust. Appointing senior leaders to these boundary-spanning roles has the potential to accelerate collaboration alongside the development of governance arrangements and relationship building.

Rather than prescribing a specific method, system leaders have focused on identifying the common principles and components of different methods, 'going with the grain' of these methods,

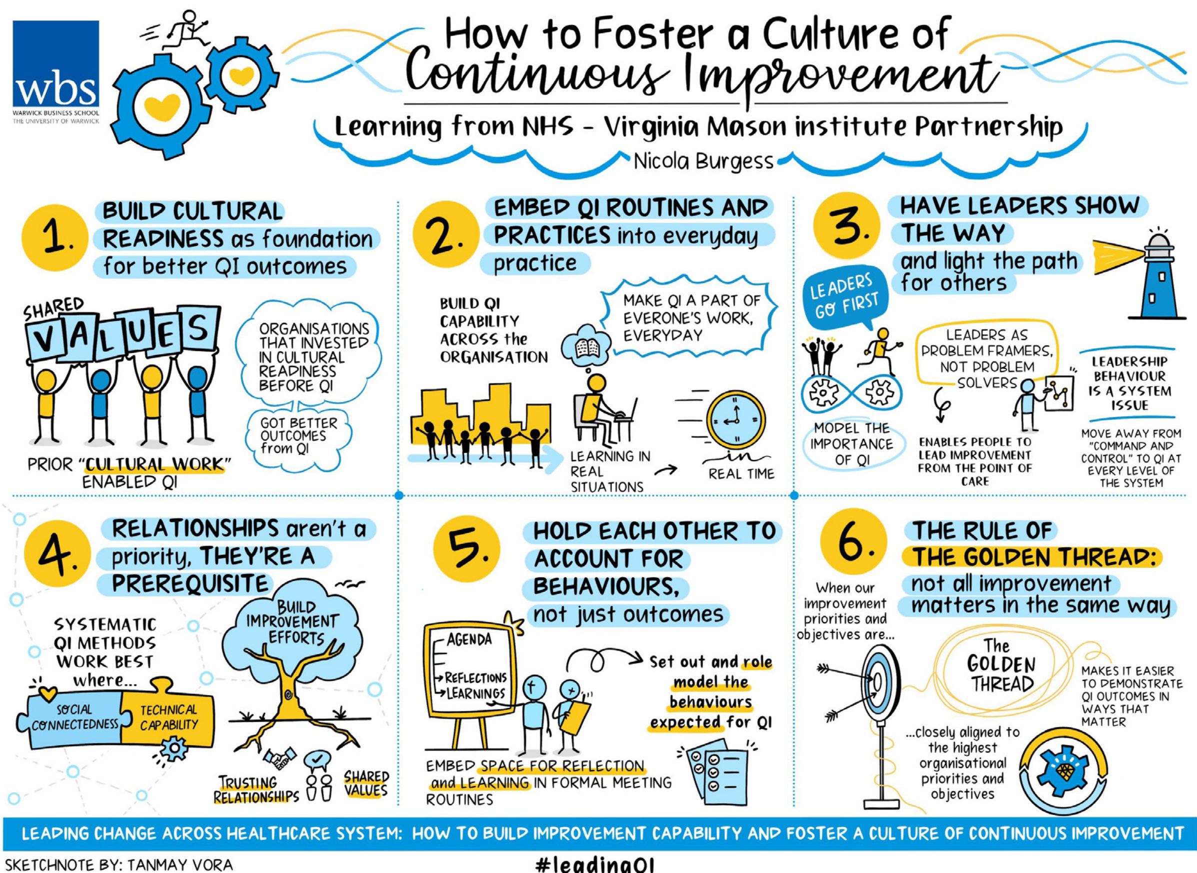
and valuing a 'thriving village' of approaches in the words of one of the systems studied. The value of methodological pluralism is recognised not just in relation to care delivery but also other approaches. For example, Wigan employed community development in delivering its population health ambitions. Examples from Lancashire and South Cumbria and Surrey Heartlands described earlier illustrate how other systems are using community development in their work.

The need for pluralism in the teams doing improvement work was also recognised. This was particularly apparent in Healthcare Improvement Scotland and its use of multidisciplinary teams with skills in quality improvement, service design, strategic planning, change management, clinical leadership, lived experience, role redesign and other technological innovation. In some systems outside the United Kingdom, for example Mayo Clinic, system engineers are particularly valued for their contribution.[13]

In all systems there is ongoing investment in staff training and supporting partners in developing and sharing their capabilities. Systems are also investing in the development of leaders, as illustrated in the programmes established in Lancashire and South Cumbria and Surrey Heartlands. Leadership development is focusing increasingly on multi-professional groups involving leaders from a variety of organisations and backgrounds.

Improvement leads emphasised the value of testing and learning what does and does not work, as the focus shifts from organisations to neighbourhoods, places and systems. This echoes the approach taken in Improving Adult Care Together. Leaders are also seeking to demystify quality improvement by avoiding jargon and seeing improvement work as 'everybody's business'. Securing the endorsement of NHS trust leaders and leaders in other partners was identified as a key requirement in one of the roundtables that informed this report.

A recurring theme Is that improving health and care requires culture change with the emphasis on commitment not compliance, collaboration and team work, and learning and curiosity. Nicola Burgess, who led the evaluation of the Virginia Mason partnership with the NHS at Warwick Business School, argues that cultural readiness is the foundation on which improvement succeeds or fails.[37] This includes developing cultures in which leaders can challenge each other and ensure that difficult issues are not 'swept under the carpet'.



In many systems the use of data to underpin improvement work is strongly emphasised. This includes data on healthcare delivery, such as GIRFT, and on population health, as in work in Dorset and Lancashire and South Cumbria. The need to fill gaps in data, for example on patient and staff experience, was mentioned as well as the need to improve access to data. Using data is one way of identifying variations in performance that may be challenging for some partners.

Health innovation networks have a prominent role in some systems working in partnership with ICBs and providers. Some systems are exploring how the expertise and capacity of existing networks (including but not limited to health innovation networks) can be more effectively aligned with their work.

External experts and partners have also been involved including Helen Bevan, Sue Holden, David Fillingham, John Clarkson, Newton Europe and international leaders/exemplars such as the IHI, VMI and HIS. These partners supplemented available capacity and capability in ICSs as well as providing a challenge to established improvement approaches. System leaders spoke of the value of 'stealing with pride' from organisations in other countries that were further ahead in their improvement journeys.

> "System leaders spoke of the value of 'stealing with pride' from organisations in other countries that were further ahead in their improvement journeys."

The value of peer-to-peer collaboration is recognised and support from the Leading Integration Peer Support Programme has already helped Gloucestershire, for example. The Health Foundation's support was welcomed, as in the work of the Q community and a repository of reports and resources extending back several years (see page 123).

The systems included in this study vary in their size and complexity. Leaders in some of the smaller systems reported the value of working in a context in which leaders and many staff had well-established relationships on which to build. Leaders in some of the larger systems stated that there could be difficulties in building common cause across large and dispersed geographies where relationships were less mature.

Set against this, our case studies illustrate that some of the larger systems (NENC, LSC and WYHCP) had made substantial progress

in working with partners to develop shared visions and agree goals and priorities. This was in part because these systems had invested time since STPs were established in 2016 to build more collaborative relationships and cultures and develop distributed leadership. The work of WYAAT is a standout example.

Size in itself may not explain variations in progress in ICSs because, as we have noted, many other factors are at work. They include the role of leaders, the strength of relationships, and the willingness of partners to move beyond the concerns of their organisations and embrace a systems perspective. It is also worth emphasising that bringing about improvements on a large scale can be achieved when systems work together, as shown in the case study of Thames Valley.

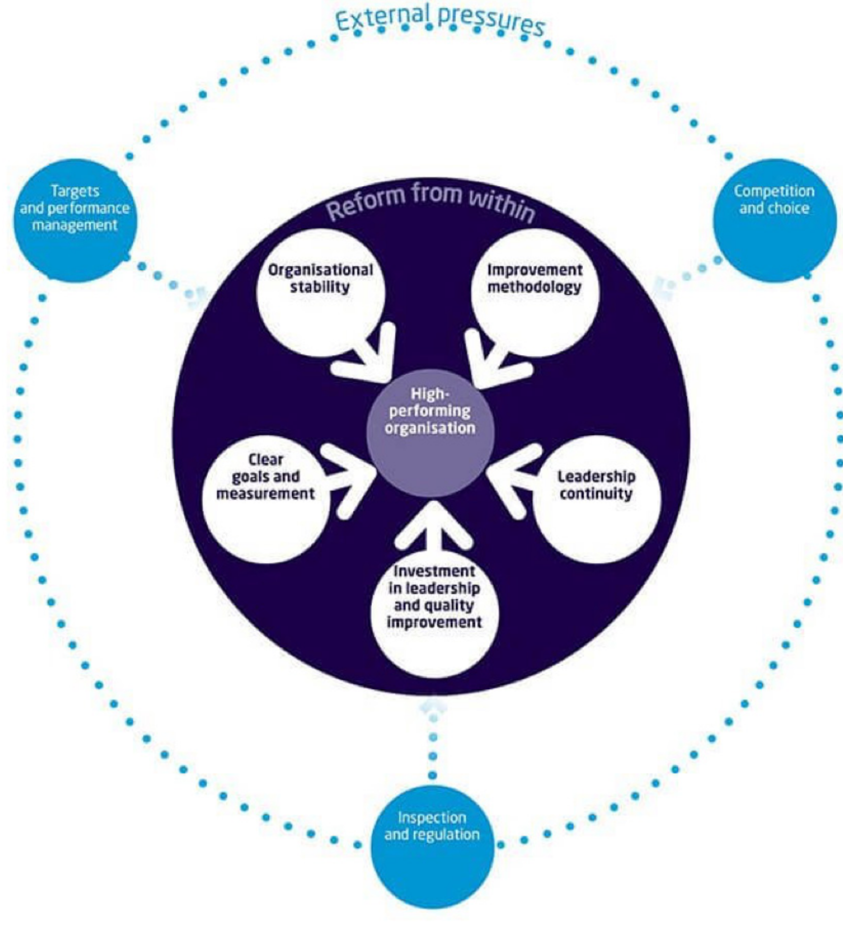
Implications for integrated care systems

Integrated care systems became statutory bodies at a time of unprecedented operational challenges. They were also faced with making the transition from previous NHS bodies and setting up governance and leadership arrangements to discharge their responsibilities. The requirement that they should reduce management costs by 30 per cent adds to the challenges they face. Timmins[38] has described ICSs as being ‘born into a storm’ with some more advanced in the development of partnership working and relationship building than others.

While there is broadly based support for what ICSs have been established to do, there remain questions as to whether they can deliver and how quickly. There is also concern that another layer of NHS management has been added to an already complex structure. This creates a risk of confusion about roles and responsibilities between NHS England’s regional offices, ICBs and partnerships, provider collaboratives and NHS trust boards. Resolving this confusion should be a high priority.

Studies of high-performing healthcare organisations and systems have found that they benefit from leadership continuity and organisational stability among other factors (see figure below). National leaders should therefore resist the temptation to restructure systems and focus instead on creating the conditions in which ICSs can succeed. This includes heeding the advice of Don Berwick's review following Mid Staffordshire that 'the NHS needs a considered, resourced and driven agenda of capability building in order to deliver continuous improvement'.[39]

National leaders must also ensure that their actions unleash the intrinsic motivation of health and care staff to perform to the best of their abilities. Work by the IHI on the psychology of change has outlined how this can be achieved and there were echoes of the IHI's thinking in a number of the systems included in the work reported here.[40] One example is the emphasis in NENC on co-production 'by the people being served and the workers who are serving them'.



Source:[41]

Our case studies suggest the need for caution in prescribing how this should be done. The task given to ICSs – to improve health and care at scale – is less well understood and described than how to improve the delivery of care in hospitals and other services where there is accumulated experience on which to draw. Careful thought is needed on how the recommendations in NHS IMPACT apply to ICSs, especially in view of the approach taken by systems themselves who have avoided specifying how improvement should be done or prescribing a single model.

> "NHS IMPACT must also recognise the critical role of local authorities, voluntary and community sector organisations and other partners in improving health and care at scale."

NHS IMPACT must also recognise the critical role of local authorities, voluntary and community sector organisations and other partners in improving health and care at scale. Integrated care partnerships are central to this work and are working alongside ICBs to deliver the ambitions set out in system plans and strategies. The approach to improvement adopted within the NHS needs to reflect the involvement of other partners, differences in accountabilities across the public and voluntary sectors, and the diverse aims being pursued.

Participants at one of the roundtables held during the work reported here argued that improvement work would be more effective if it were focused on a small number of priorities. The experience of the NHS Modernisation Agency, summarised at the beginning of this report, shows the risks of national bodies taking on too many programmes, thereby creating confusion within the NHS and crowding out work on issues of local importance. NHS England has a role in ensuring that this mistake is not repeated and that ICSs are able to address local as well as national priorities.

Fiona Edwards, chief executive of Frimley ICB, expressed concern that improvement was being seen as 'the next big thing' by national leaders. This created a risk of a hierarchical approach centred on the National Improvement Board. In Fiona's view, it was essential to understand that bringing about improvement requires a 'people-based approach' focused on changes in behaviours and cultures. These views were supported by another ICB chief executive who felt that the self-assessment work being led by NHS IMPACT risked becoming an exercise in assurance rather than improvement.

Avoiding these risks requires leaders and staff from across health and care who have 'been there and done it' to be closely and continuously involved in shaping how improvement can be embedded throughout the NHS. The experience of system leaders underlines the importance of relationship building, seeing frontline staff as key agents of change, and understanding the psychology of change. The work involved needs to reflect the maturity of systems, different starting points, the value of generating approaches to improvement that are owned by those doing the work, and understanding that real change happens in real work.

The case studies in this report show that ICSs have added value by identifying the improvement expertise that exists in their areas and helping organisations and services with limited resources and capabilities to access this expertise. Improvement communities and networks are playing a role alongside external experts in making this happen. Many ICSs have been resourceful in drawing on diverse sources of support even in advance of NHS IMPACT and national leadership of improvement work. This has been facilitated by the latitude ICSs have enjoyed in exploring what it means to be a self-improving system.

In doing so, ICS are building broadly based partnerships to deliver goals for improving population health. This is exemplified by experience in NENC, where system and NHS trust leaders argued that the co-existence of good services and poor health outcomes in their area offers a compelling case for the ICS/ICP to

address issues that go beyond the provision of high-quality care. In essence, this means tackling the wider determinants of health and wellbeing in partnership with local authorities, VCS organisations, educational institutions, businesses and others, and recognising the vital role of central government in tackling 'the causes of the causes'.

It also means adopting methods appropriate to this task, learning from local government and other sectors. The Wigan Deal referred to at the outset of this report shows what can be achieved drawing on the insights of anthropologists, social activists like Hilary Cottam,[42] and work on asset-based community development.[43] The NHS can and should learn from other sectors in adopting these methods and evidence on the role of community power in transforming public services.[44] This is already happening in NENC through partnership with the think tank, New Local.

Work on 'collective impact'[45,46] in other settings and jurisdictions offers insights into how these factors have enabled organisations to collaborate in tackling complex social problems, thereby achieving more than organisations who operate in isolation from each other. It is closely related to work on social movements and the need to mobilise people and resources to build momentum for change, as argued in a report by the NHS Institute for Innovation and Improvement.[47] Learning from other sectors is relevant here too.[48]

System leaders must be adaptable in working in these more fluid environments and open to new ways of leading change. As this happens, three conditions must be met: goals should be aligned at all levels – system, place, neighbourhood and among providers; various methods should be adopted appropriate to the goals being pursued; and the multifaceted nature of transformational change must be understood (as illustrated by the story of the VA in box 1) with many interlinked innovations contributing over time to improved performance.

In all of this work, leaders have a role in celebrating successes, valuing progress, generating energy and holding out hope of a better future. Leaders must also ensure that system governance and relationships facilitate difficult conversations that enable conflicts to be addressed and resolved. In the view of Fiona Edwards, chief executive of Frimley ICB, the ability to have these conversations is much more important 'than building architectures which create formal bureaucratised approaches to avoid the real work.'

In all of this work, leaders have a role in celebrating successes, valuing progress, generating energy and holding out hope of a better future.

Difficult conversations have to confront the dual loyalties of many of the leaders involved in ICBs and partnerships. A participant at one of the roundtables held during this work spoke of the tension faced by these leaders when the interests of their organisations, for example NHS trusts, are not aligned fully with system priorities. This is sometimes referred to as the 'club and country challenge.' Confronting this tension and resolving disagreements constructively is essential to avoid systems descending into chronic conflict and stasis.

> "Effective implementation means embracing complexity and being willing to test and learn from what works in different contexts."

The work of IHI and adapted by HIS suggests that improvement results from the will to change being joined with ideas and skills in implementing change. Ideas are rarely in short supply and effort is often most needed in strengthening the will to change and implementing ideas effectively in the face of complexity. In essence, will comes down to collaborative leadership, the ability of system and organisational leaders to find common cause, and a structured approach to improvement and innovation. Effective implementation means embracing complexity and being willing to test and learn from what works in different contexts.

System leaders interviewed for this report are impatient to demonstrate the impact of their work. Examples such as work in Wakefield in reducing demand on acute hospitals by the use of data and partnership working illustrates the possibilities of place-based improvement. Stories like Wakefield's help build confidence that the NHS and its partners are on the right track and more stories like this are needed in the next phase of work.

The following framework, developed by the Health Foundation's Q community, provides a useful way of thinking about the different domains and distinct considerations associated with improvement that spans places and systems.

Where next?

The level of ambition behind NHS IMPACT and ICSs becoming self-improving systems should not be underestimated. No country in the world has put in place a learning and continuously improving system on the scale of England. The National Improvement Board should seek to learn from the way in which HIS has created an environment in Scotland, in which its expertise is pulled in by NHS organisations rather than being pushed out. There is also learning from international exemplars of improvement discussed in this report and how they have delivered improvement 'from within'.

No country in the world has put in place a learning and continuously improving system on the scale of England.

As this happens, there needs to be realism about the time it will take to do so and constancy of purpose in pursuing this ambition. Experience in the 2000s of the profusion of policies and programmes on quality improvement, discussed at the outset of this report, underlines the need to pursue a coherent, well-designed strategy over time. There is learning again from Scotland, where work on patient safety benefited from strong and consistent multiparty political support, and from the improvement journeys of high-performing systems in other countries.

Our case studies show how work on improvement encompasses various care settings, care pathways and integration of services. It also embraces action outside the NHS as local authorities, voluntary and community sector organisations work with the NHS and others to deliver improvements in population health. This includes work to understand what matters to people and communities and working with them to co-design and co-produce appropriate interventions. Partnerships with local authorities and

others are enabling the NHS to learn how to do so.

National leaders should take forward NHS IMPACT with an explicit commitment to engage leaders and staff from across the NHS and beyond as well as people with lived experience. They must also ensure that improvement at all levels focuses on a realistic number of programmes. The Health Foundation and the NHS Confederation should work with the National Improvement Board and others as this happens. The Local Government Association and organisations like National Voices have vital contributions to make, given the growing interest in population health and community engagement.

What then are the priorities with the needs of ICSs particularly in mind and what resources are available to support progress? This report has outlined many of the actions now required and we conclude by highlighting five of particular importance. These actions take on even greater urgency at a time when ICSs face growing operational and financial pressures and the limits on performance management as the principal means of bringing about change in the NHS become ever clearer.

1. Build improvement capability and understanding of what works

An important starting point is Don Berwick's counsel that the NHS requires a system of support focused on building capability in improvement. The Q community organised under the auspices of the Health Foundation has been at the forefront of capability building, alongside the efforts of an increasing number of NHS organisations and the leadership of former national bodies like NHS Improvement and regional agencies such as AQUA. Our case studies show how ICSs are drawing on these efforts in developing improvement communities and sharing expertise with organisations that may lack relevant capabilities.

There is also a growing body of knowledge in the work of the Healthcare Improvement Studies Institute (THIS), AQUA, HIS and others about the core components of improvement and the effectiveness of different approaches. Much of this knowledge relates to improving care delivery in teams and organisations, such as work on flow and the use of improvement collaboratives. Ensuring that this work is easily accessible is essential to support the aims of NHS IMPACT and underpin improvement activities at different levels.

This report shows how systems are also working to improve population health, where methods are less well understood and described than methods used in improving care delivery. An early priority should be to fill this gap by identifying how ICSs are seeking to improve population health and what is and is not working. This includes identifying the capabilities needed in this work as well as the methods available.

Specifically, case studies and evaluations of the use of community development and other interventions in systems and places that are employing these methods are required. In this way it should be possible to build on learning from Wigan and other pioneers, as well as international experience.[49] A recent review of tackling inequalities through general practice found that community-centred approaches was one of five key principles found to be important in this work.[50]

2. Enable peer-to-peer learning

Our case studies show how ICSs are using peer-to-peer learning both in their own systems and through collaborating with other ICSs. In the next phase of development, priority should be given to extending this work and assessing how peer-to-peer approaches are being used in ICSs. Evidence on the work of improvement networks and communities of practice and the role they played in the response to the COVID-19 pandemic is relevant here.[20]

Issues to be explored include how existing administrative structures support networks, for example by aligning the work of health innovation networks and other agencies with ICSs and their improvement communities. Effective networks have the potential to enable shared learning and use of improvement expertise, including in organisations and services with limited resources and capabilities. Networks also help foster the social connectedness that research shows to be a feature of improvement that has an impact.

A good example can be found in the partnership between the Virginia Mason Institute (VMI) and the NHS, in which five trusts adapted learning in quality improvement. The evaluation conducted by researchers at Warwick Business School reported that the highest-performing trust had the most distributed social network and it concluded that social connectedness appeared to be correlated with the efficacy of improvement activity.[11] These findings underline the importance of supporting those doing improvement to work and learn together and is reinforced by the emphasis placed on learning and improvement communities in our case studies.

3. Nurture learning systems

The NHS Confederation and the Health Foundation are well placed to provide support through their networks as a way of facilitating the sharing of learning between systems in real time and identifying worthwhile innovations in improvement practice. This includes breaking down barriers between teams, organisations and systems and tackling the 'club and country' tension referred to earlier. Improvement communities and provider collaboratives are making progress on these issues and more stories are needed of how they are doing so.

Research into the spread of innovations points to the limits of passive diffusion and 'central broadcasts', the need to 'unleash

the passion and creativity of local managers and clinicians', the importance of removing barriers to progress, and of celebrating breakthrough ideas and practices.[51] As this happens, it is important to understand that spreading innovations requires 'a complex process of adaptation to take something that works in one context and make it work in another' (ibid).

Change does not follow a linear path in a complex adaptive system like the NHS and those leading improvement operate in a context characterised by both inertia and innovation. As HIS emphasises in Scotland, leaders must secure commitment to change and foster an appetite for learning and improvement. Learning needs to be underpinned by use of data to understand need and demand for care and to develop actionable insights as illustrated by the case studies in this report and other work.

Some ICS leaders have found it helpful to use experience in other countries in developing their approaches and would value support in doing so in future. This includes accessing reports on international exemplars and hearing from leaders in other countries through conferences, webinars, podcasts and other means. It could extend to the use of learning networks bringing together leaders from different countries both virtually and in person. The International Foundation for Integrated Care could play a part in this.

4. Create a context for improvement based on high trust and low bureaucracy

As the voice of the healthcare sector, the NHS Confederation is ideally positioned to make the case for greater clarity in roles and relationships in delivering improvement and promoting transformational change, working with NHS England and others. This includes recognising the contribution of work in neighbourhoods and places and the role of provider collaboratives alongside ICBs. The essential role of local authorities and voluntary and community sector organisations also needs to

be better understood and valued as NHS IMPACT is rolled out, including through integrated care partnerships and health and wellbeing boards.

System leaders involved in the work reported here expressed concern that top-down performance management and associated behaviours might derail improvement, which hinges on the intrinsic motivation of staff and a belief in commitment and not compliance to bring about change. Don Berwick's report following Mid Staffordshire was explicit in its warnings about the toxic effects of fear and blame and the barriers they create to learning and improvement.[39] The recent Messenger review of NHS leadership found 'too many reports to ignore of poor behavioural cultures and incidences of discrimination, bullying, blame cultures and responsibility avoidance'.[52]

There is a stark contrast with the work of one of our international exemplars, Canterbury District Health Board in New Zealand, where chief executive David Meates adopted a 'high trust, low bureaucracy' philosophy in leading transformational changes. This is quite different from the emphasis in the NHS on assurance, 'constant checking and reporting' in the words of one interviewee, and upwards accountability. Former chief executive of UCLH foundation trust, Marcel Levi, contrasted the agile response to the COVID-19 pandemic in parts of London with the bureaucratic and slow-moving approach used in developing partnership working pre-pandemic, indicating a clear preference for the former.[53]

ICSs are beginning to address these issues by devolving more responsibilities to place partnerships and focusing on those functions that are best discharged by the system. The new operating framework for NHS England includes explicit commitments to system leaders having 'the agency and autonomy to identify the best way to deliver agreed priorities in their local context.' The framework builds on earlier statements by health ministers and national NHS leaders that ICSs should operate on the basis of subsidiarity enabled by reduced bureaucracy.[54,55]

The Hewitt review set out proposals for turning these aspirations into practice.

There is an opportunity for the Care Quality Commission (CQC) to play a positive part through the assessment framework it is developing for ICSs and ensuring this is used as a basis for improvement and not just judgement. The framework focuses on leadership, integration, and quality and safety, and assessments are intended to provide a basis for systems themselves to learn and improve – for example in partnership working - and to inform the public. NHS England will also continue to assess the performance of ICSs and it is essential that its work aligned with that of the CQC.

5. Support system leadership for improvement

Last but not least, the Health Foundation and the NHS Confederation should continue to support the development of system leadership and the leadership styles and behaviours needed to deliver improvement at scale. Our case studies include examples of what this means: a commitment to collaboration through leaders in systems, places and neighbourhoods finding common cause with peers in partner organisations around shared aims and ambitions, and having difficult conversations to resolve differences. ICBs and partnerships have a pivotal role in modelling these and other system behaviours.

For the avoidance of doubt, leadership development should focus not only on those in designated system roles but also on organisational leaders and others whose collaboration and commitment to improvement is essential. Organisation development interventions aimed at fostering collaboration and system thinking have been used to good effect in some of the case studies in this report, alongside the adoption of an improvement mindset. Supporting leaders to work and behave differently should be a high priority, building on the approach

outlined in NHS IMPACT and overcoming the ‘club and country’ tension that remains a barrier to progress.

Developing system-wide improvement approaches

The team managing the Q community at the Health Foundation and NHS Confederation worked with local system leaders to distil five principles for working effectively across local systems to develop shared improvement approaches. These principles align well with the findings of this report.

Developing system-wide improvement approaches

Five principles for collaborating across local systems to develop shared improvement approaches
Read the full principles at **q.health.org.uk**

Define scope and goals together

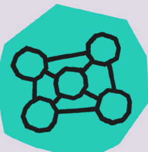
Involve stakeholders from across your system to define how shared approaches add value. Remember the purpose: to improve health outcomes and experiences for your population.

Build relationships and trust

Invest time and energy in developing relationships and building connections across the system. This underpins the success of shared improvement approaches.

See diverse expertise as an asset

Focus on the core ideas shared by different methods. This will help make system-wide improvement more accessible, inclusive, practical, and productive.



Develop shared system leadership

Collective ownership and leadership are needed to make progress. Identify the different roles needed and who is most suitable to lead each part.

Use an improvement mindset

Try out different things, learn from them and make changes. Don’t be afraid to fail and learn from what doesn’t work, as much as what does work.

In partnership

About the author

Chris Ham is emeritus professor of health policy and management at the University of Birmingham and co-chair of the NHS Assembly. He was chief executive of The King's Fund between 2010 and 2018 and has served on a number of NHS boards. He was awarded a CBE for services to the NHS in 2004 and a knighthood for services to health policy and management in the Queen's Birthday Honours in 2018. He has worked at the interface of research and health policy, including serving as the director of the strategy unit in the Department of Health in London between 2000 and 2004. He is the author of over 20 books and numerous articles in scientific journals.

Chris has acted as an adviser to a number of international agencies including the World Health Organization and the World Bank. He has also advised parliamentary committees in the UK, the Audit Commission, the National Audit Office, and professional bodies such as the Royal College of Physicians, the British Dental Association and the British Medical Association. He has served on the boards of the Health Foundation, the Canadian Health Services Research Foundation, and the Canadian Institutes of Health Research. He is a founding fellow of the Academy of Medical Sciences, a fellow of the Royal Society of Medicine, and a former vice-president of the Patients' Association.

Chris is an honorary fellow of the Royal College of Physicians of London and the Royal College of General Practitioners. He served as chair of the Coventry and Warwickshire integrated care system and as non-executive director of the Royal Free London Hospitals NHS Foundation Trust between 2019 and 2021.

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Any errors or omissions are my responsibility.

Chris Ham

October 2023.

Practical insight and resources

Provided by the NHS Confederation, the Q community and the Health Foundation

The partnership between the NHS Confederation, the Health Foundation and Q aims to make it easier for leaders in health and care systems to make use of freely available improvement learning and assets that already exist within the sector. This section highlights a selection of resources and examples that might be relevant to the needs and priorities of those working within and across systems identified in this report.

Building improvement capability and understanding of what works

System goals will not be achieved through a handful of good ideas, but through thousands of people testing innovations and ideas, large and small, and collaborating effectively across disciplines and sectors.

- Q is a community of thousands of people across the UK and Ireland, collaborating to improve the safety and quality of health and care. It offers dozens of online groups that you can join to share learning and collaborate
- Q's publicly searchable directory provides a good way to identify who has experience in improvement and interest in collaborating across each sector.

Enable peer-to peer-learning

Systems see convening and enabling improvement as central to their added value.

The NHS Confederation's members can connect with their peers from across health and care through its dedicated forums. Peers come together to share experiences and challenges, learn from one another and connect directly with policy makers to influence national thinking. Forums include CEOs, chairs, non-executive directors, and for women leaders, BAME leaders and LGBTQ+ leaders.

Within Q is a source of practical expertise in the effective design and development of collaborative improvement networks. Some tools include:

- Creative Approaches to Problem Solving: a toolkit of 25 tried-and-tested methods for creative collaboration and problem-solving.
- Effective networks for improvement: a report helping to develop and manage effective networks to support quality improvement in healthcare
- Skills for collaborative change: a practical tool from Q and Nesta setting out the skills and attitudes needed for collaborative and creative problem-solving.

Case example: The Q community working with South West London ICB has created a dedicated Community of Practice (CoP) expert convener role to link the improvement community, within member organisations to system level improvement work. Along with Hertfordshire and West Essex ICB, Q has been supporting the development of an ICS QI network. Through bringing together improvement expertise and learning from different organisations the network is getting traction on system priorities.

Nurture learning systems

This report highlights the support that the NHS Confederation and the Health Foundation's Q community can provide through its networks as a way of facilitating the sharing of learning between systems in real time. It also illustrates the importance and challenges of having the data and analysis skills needed to understand and address system goals to reliably deliver improvement. Some useful links include:

- Developing learning health systems in the UK: Priorities for action
- The Networked Data Lab: a collaborative network of analytical teams using linked data sets to better understand and address challenges that span sectors.
- Hexitime, an improvement focused time-banking platform that has grown with the support of Q, is an example of an innovative way to stimulate and support people to exchange skills across sector
- NHS Confederation's international links can help systems to benefit learning from international knowledge, good practice and opportunities.

Case example: In the Nottingham and Nottinghamshire ICS the Q Exchange funding programme has enabled the creation of a cross-system quality improvement design collaborative. The collaborative has created a single point of contact around improvement resources within the ICS. People can submit cross-system ideas for improvement projects as well as sourcing support and coaching to develop improvement skills.

Support system leadership for improvement

The NHS Confederation, Health Foundation and Q partnership will draw on work they and others have done to define and build the senior leadership skills and behaviours needed to enable

improvement across systems. Connecting board-level and frontline improvement leadership through our combined networks supports the distributed leadership identified as needed in the report.

Some examples of where we are supporting system leadership:

- Connected Leadership, a pilot leadership programme for ICB CEOs, ICB chairs and ICP chairs, co-designed with participants and delivered in partnership with the Forward Institute
- The Generation Q fellowship, which enabled leaders to develop the relational, technical, personal and contextual leaderships skills required to lead change across complex systems.
- NHS Confederation, the Local Government Association and NHS Providers are working together to deliver a range of free, bespoke support for local health and care systems The Leading Integration and Peer Support programme is independent, 'from and of the sector' and includes peer reviews, workshops, critical friend support, mentoring and best practice sharing, all delivered by peers with extensive expertise leading health and care.
- EDI Directors Programme is for strategic leaders delivering improvement through tackling inequality. Supporting the need for collaboration and inclusivity across systems, this programme works with leaders to develop their skills, equipping them with tools, ideas and insights, and connecting them with a community of their peers.

Developing system-wide improvement approaches: Five principles for working across local systems to develop shared improvement approaches.

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