

# Place-based systems of care

A way forward for the NHS  
in England

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# Summary

The NHS is facing growing pressures, with finances deteriorating rapidly and patient care likely to suffer as a consequence. It is also developing new care models designed to deliver services more appropriate to the changing needs of the population.

The NHS is seeking to tackle these challenges in the context of organisational arrangements that are more complex and fragmented than at any time in its history. The question is how to adapt these arrangements and make them fit for purpose while avoiding another damaging reorganisation.

This paper argues that providers of services should establish place-based 'systems of care' in which they work together to improve health and care for the populations they serve. This means organisations collaborating to manage the common resources available to them.

The approach taken to developing systems of care should be determined by NHS organisations and their partners, based on a set of design principles that we outline in this paper. These principles include developing an appropriate governance structure, putting system leadership in place and developing a sustainable financial model.

Government and national bodies in the NHS should work to remove the barriers that get in the way of working in place-based systems of care and should themselves work in a co-ordinated way to support the development of these systems. This includes creating stronger incentives for systems of care to evolve to tackle current and future challenges.

Fundamental changes to the role of commissioners are needed to support the emergence of systems of care. Commissioning in future needs to be both strategic and integrated, based on long-term contracts tied to the delivery of defined outcomes. Scarce commissioning expertise needs to be brought together in footprints much bigger than those typically covered by clinical commissioning groups (CCGs), while retaining the local knowledge and clinical understanding of general practitioners (GPs).



Systems of care hold out the prospect of NHS organisations developing services that are financially and clinically sustainable and putting in place new care models that are able to improve the health and wellbeing of the populations they serve. The alternative is for each NHS organisation to adopt a ‘fortress mentality’ in which it acts to secure its own future regardless of the impact on others.

The argument of this paper is that collaboration through place-based systems of care offers the best opportunity for NHS organisations to tackle the growing challenges that they are faced with. It will, however, require organisational leaders to surrender some of their autonomy in pursuit of the greater good of the populations they collectively serve, and national leaders to act urgently to enable systems of care to evolve rapidly.



# 1 From fortresses to systems

The NHS in England is facing growing financial and service pressures at a time of rising demand and constrained resources. It is seeking to tackle these pressures in the context of the Health and Social Care Act 2012 and its legacy of organisational arrangements that are more complex and fragmented than at any time in the history of the NHS (see [Ham et al 2015a](#)).

This paper argues that making progress in this environment depends on providers working together in place-based ‘systems of care’ while avoiding further destabilising and distracting changes to the structure of the NHS. It also argues that commissioning should be much more integrated and strategic in order to support the development of place-based systems of care.

There is real urgency in tackling these issues as NHS finances are already in crisis and patient care is likely to suffer as a consequence. Leaders at both national and local levels cannot afford to indulge in navel-gazing and need to decide how the proposals set out in this paper can be taken forward in 2016 and beyond.

The case for systems of care derives in part from the absence of a designated system leader in the English NHS following the abolition of strategic health authorities in 2013. One of the consequences has been to leave a vacuum in the organisation of the NHS in relation to the oversight of services at regional and local levels. The contribution of strategic health authorities when they worked at their best has not been replaced and has left a sense in many areas that ‘no one is in charge’ ([Timmins 2015](#)).

Previous work by The King’s Fund ([Ham et al 2013](#)) has highlighted the risks this entails in London, for instance, where financial and service pressures are particularly acute. The option of ‘constellations of leadership’ emerging to fill the vacuum left by the abolition of strategic health authorities, put forward in the report, has been only



partially realised, often because the skills needed to work across organisational and service boundaries are in short supply. A notable exception is north-west London where commissioners have come together to reconfigure services.

A different example is UCL Partners, which has facilitated improvements in clinical care among providers in parts of London and south-east England. Elsewhere it has proved difficult to put in place the system leadership needed to bring about changes in how care is delivered. The separation of responsibilities between providers and commissioners adds a further layer of complexity in an already fragmented environment, accentuated by the sheer number of organisations involved in providing and commissioning care in England.

The alternative to place-based systems of care is for each NHS organisation to adopt a ‘fortress mentality’, acting to secure its own future regardless of the impact on others. A fortress mentality is a logical response in the existing NHS environment where provider autonomy, competition and regulation figure prominently. Faced with persistent demands from regulators to improve performance, the leaders of provider organisations in particular are under pressure to focus on the services for which they are responsible rather than working with other providers and commissioners for the greater good of the populations they serve.

The obvious risk in a fortress mentality is that ‘success’ for one organisation almost invariably accentuates the challenges facing others. Oversimplifying only a little, an acute provider that improves its financial performance by increasing activity may add to the pressures facing commissioners who may lack the resources to pay for it. It may also frustrate plans to give greater priority to mental health, community-based services and primary care.

Organisations commissioning and providing care with a common pool of limited resources find themselves in a zero-sum game in which winners co-exist with losers in a set of relationships that are often fragile. Failure to act collectively is likely to result in poor outcomes for the population and at worst a descent into a ‘war of all against all’, to borrow the words of the philosopher Thomas Hobbes. The central argument of this paper is that NHS organisations must work together and with others to govern the common resources available for meeting their population’s health needs.



If the fortress mentality prevails, the major challenges facing local health systems and the populations they serve are likely to go unmet. These well-known challenges – such as delivering care for people with long-term conditions and managing demand for urgent care services – are best tackled by collective action across organisations and services. Collective action is also needed to improve the health and wellbeing of the population by acting on the wider social, economic and environmental determinants of health (Canadian Institute for Advanced Research *et al*, cited in [Kuznetsova 2012](#); [Booske \*et al\* 2010](#); [Marmot \*et al\* 2010](#); [McGinnis \*et al\* 2002](#); [Bunker \*et al\* 1995](#)).

The case set out here echoes the view of the 2014 BBC Reith lecturer, Atul Gawande, who argued that we are living in the ‘century of the system’ ([Gawande 2014](#)). By this he means that individuals and organisations cannot solve the problems facing today’s society on their own. Instead, we must design new ways in which individuals can work together in teams and across systems to make the best use of collective skills and knowledge.

We believe that systems of care offer both short- and long-term solutions to the challenges facing the NHS. In the short term, they provide a way for local health services to work together to tackle the immediate financial and service pressures that are universally faced across the country. In the longer term – and more fundamentally – they provide a platform for implementing radically new models of care across local areas in England, with the aim of improving population health and wellbeing. Elsewhere we have described this as a shift towards population health systems ([Alderwick \*et al\* 2015](#)).

## The rationale

The need for organisations to work together in place-based systems of care has been recognised recently in the so-called ‘success regime’ developed by NHS England, Monitor and the NHS Trust Development Authority, working with the Care Quality Commission.

This is described as a ‘whole-systems intervention’ where national bodies work with commissioners and providers in areas of England facing deep-seated challenges ([NHS England 2015](#)). Three areas have been identified initially for participation in the regime, which involves a single diagnosis of the issues facing the health and care economy, leading to a set of interventions and support to bring about improvement.



Unlike previous approaches focused on individual organisations, such as the special measures programme, the regime adopts a place-based approach in which all relevant NHS organisations are involved.

This paper argues that many of the elements of the success regime should be adopted and adapted in other areas of England, whether or not they have deep-seated challenges. The potential benefits include the opportunity to:

- avoid place-based discussions descending into a zero-sum game that inhibits the development of collaborative working between local NHS leaders
- develop new care models that span organisational and service boundaries, supported by new approaches to commissioning and paying for care
- establish robust governance arrangements that balance organisational autonomy and accountability with a commitment to partnership working and shared responsibility
- develop services that are financially and clinically sustainable through greater integration of care and a focus on improving population health and wellbeing
- provide a foundation for collaboration with a wider range of organisations from different sectors
- put in place the leadership required to work in this way by sharing expertise and skills in different organisations
- work in partnership with the public and local communities to transform the way that services are delivered
- enable national bodies to work differently and in a joined-up way to support providers and commissioners in finding solutions to their challenges.

### Different types of emerging systems in the NHS

There are similarities between what we are proposing and plans to devolve responsibility for public services in Greater Manchester, which go beyond the NHS



to encompass a wide range of services. There are also similarities with the acute care collaboration vanguards programme, which includes three approaches:

- accountable clinical networks linking district general hospitals and teaching hospitals for key services such as cancer care
- clinical services at district general hospitals run by specialists from regional centres of excellence
- NHS foundation groups in which high-performing NHS hospitals establish hospital chains.

The third of these approaches is a development of thinking put forward in the Dalton review (Dalton 2014), which sets out a range of ways in which provider organisations might work together in future. An important difference between our approach and the Dalton review is our argument for a place-based approach in which providers in the same area are supported to collaborate. This is based on a conviction that, for the most part, health care provision is essentially local and the opportunities to develop systems of care are therefore best pursued among those serving the same or similar populations.

Similarities can also be found in the approaches being taken by multispecialty community provider and primary and acute care system vanguard sites, which involve providers and commissioners in a local area working together to develop new models of health care. Ministers and NHS leaders have drawn parallels with accountable care organisations (ACOs) in the United States in discussing new care models needed in the NHS in England. We discuss ACOs and new care models in section 3.

### A new approach to the challenges facing the NHS

Place-based systems of care are quite different from a number of approaches that have been used in the NHS in the past. Most obviously, we are not advocating mergers and acquisitions, for the simple reason that they have a mixed record and typically take an age to transact. There are also substantial costs involved in mergers, which are not typically repaid by the benefits initially promised or expected (Collins 2015a). An analysis of the impact of mergers between NHS hospitals on financial



performance, productivity, waiting times and measures of clinical quality found little evidence of improvement in any of these areas, and on some measures performance actually declined (Gaynor *et al* 2012). Evidence suggests that it is clinical and service integration that really matters, not organisational integration (Curry and Ham 2010).

For the avoidance of doubt, we are also not proposing top-down structural change to the NHS, because of the well-known costs involved and the limited evidence of benefits. In line with our work on reforming the NHS from within (Ham 2014), we argue that the approach taken to systems of care should be determined within each area using a common set of design principles, which are outlined in the next section of this paper. As this happens, it will be important to draw on previous experience in the NHS, including in the use of clinical and service networks, which offer some parallels with what we are proposing, as well as experience in other parts of the public sector and other sectors too.

Place-based systems most certainly do not involve the reinvention of strategic health authorities. This is because the systems that we are proposing would be developed and established by NHS organisations and their partners rather than being a formal part of the NHS structure in England. Systems of care would also vary in their functions and form and would exist only for as long as the organisations involved think they serve a useful purpose.



## 2 Design principles to guide systems of care

This section sets out a small set of design principles to guide the development of place-based systems of care in the NHS. This is because complex systems, such as health services, are governed by simple rules (Plesk 2001). As the systems of care that we are proposing are very different from the way that health services are currently organised, they will require new rules to guide the way they work.

In developing these principles, we have drawn on the work of Elinor Ostrom and others on managing common pool resources (*see* Ostrom 1991, 2010). Common pool resources are things that are more or less available to everyone, but where what we use effectively ends up taking away from others – things such as land for grazing animals or water for irrigation. We have done this because local health services in England are essentially common pool resources too. Put simply, providers of services in a local area have a limited set of resources to draw on when people need them – say staff or buildings – which are paid for from a limited pot of money allocated to health services. If too many resources are used by one set of providers, or one set of patients, fewer will be available for others.

The problem with common pool resources is that they can run out if they are not managed effectively – what Hardin (1968) famously described as the ‘tragedy of the commons’. If individuals or organisations act independently of others – for example, if NHS providers adopt the fortress mentality described earlier in this paper – the common pool of resources is likely to be used unsustainably. In the end, of course, this is worse for everyone. Traditional policy responses to this problem include turning to the state or the market.

The research of Ostrom and others shows how this tragedy can be avoided not by states or markets but by local communities developing their own arrangements for managing common pool resources. In many examples across the world, resources such as irrigation systems, forests and fisheries have been successfully governed by communities who define their own rules and approaches to how resources will be



used. Based on an analysis of cases such as these that worked well, as well as ones that failed, Ostrom's work identifies a set of principles that characterise successful approaches to governing common resources (see [Ostrom 2010](#), p 13). While these principles should not be applied uncritically to health services and require some adaptation – as McGinnis's (2013) discussion of the principles in the US context shows – they provide useful pointers for the systems of care that we are proposing.

We have also drawn on other work about how partners can achieve collective impact (such as [Kania and Kramer 2011](#)), as well as our own work on integrated care and population health (such as [Alderwick et al 2015](#); [Curry and Ham 2010](#)), to develop the following 10 principles to guide the development of systems of care in the NHS.

1. Define the population group served and the boundaries of the system.
2. Identify the right partners and services that need to be involved.
3. Develop a shared vision and objectives reflecting the local context and the needs and wants of the public.
4. Develop an appropriate governance structure for the system of care, which must meaningfully involve patients and the public in decision-making.
5. Identify the right leaders to be involved in managing the system and develop a new form of system leadership.
6. Agree how conflicts will be resolved and what will happen when people fail to play by the agreed rules of the system.
7. Develop a sustainable financing model for the system across three different levels:
  - the combined resources available to achieve the aims of the system
  - the way that these resources will flow down to providers
  - how these resources are allocated between providers and the way that costs, risks and rewards will be shared.



8. Create a dedicated team to manage the work of the system.
9. Develop 'systems within systems' to focus on different parts of the group's objectives.
10. Develop a single set of measures to understand progress and use for improvement.

These principles are now described in more detail.

### Define the population group served and the boundaries of the system

The starting point in establishing place-based systems of care is to define the population served and the boundaries of the system. In some cases this will be relatively straightforward – Cornwall and the Isle of Wight being obvious examples – but in others it will be more complex, particularly in large urban areas where people move across administrative boundaries to access care and support. Local systems may also exist within regional systems (as in the areas that make up Greater Manchester), requiring different arrangements at different levels.

Whatever geographical boundaries are chosen, place-based systems of care should be focused on the whole of the population that they serve – in other words, they should take responsibility for all the people living within a given area – rather than focusing only on one part of a local population such as older people or people with specific medical conditions. The latter approach risks creating new forms of fragmentation in addition to those that currently exist, when the rationale of systems of care is to bring organisations together around the population they serve.

### Identify the right partners and services

While place-based systems of care will have a strong focus on the NHS, they should also involve local authorities, the third sector and other partners. This is particularly the case where the aim is to focus on population health and not just health and care services. In practice, some organisations may prefer to play a supporting role rather than a leading role in the arrangements we have described, depending on the contribution they make to the health of the population concerned.

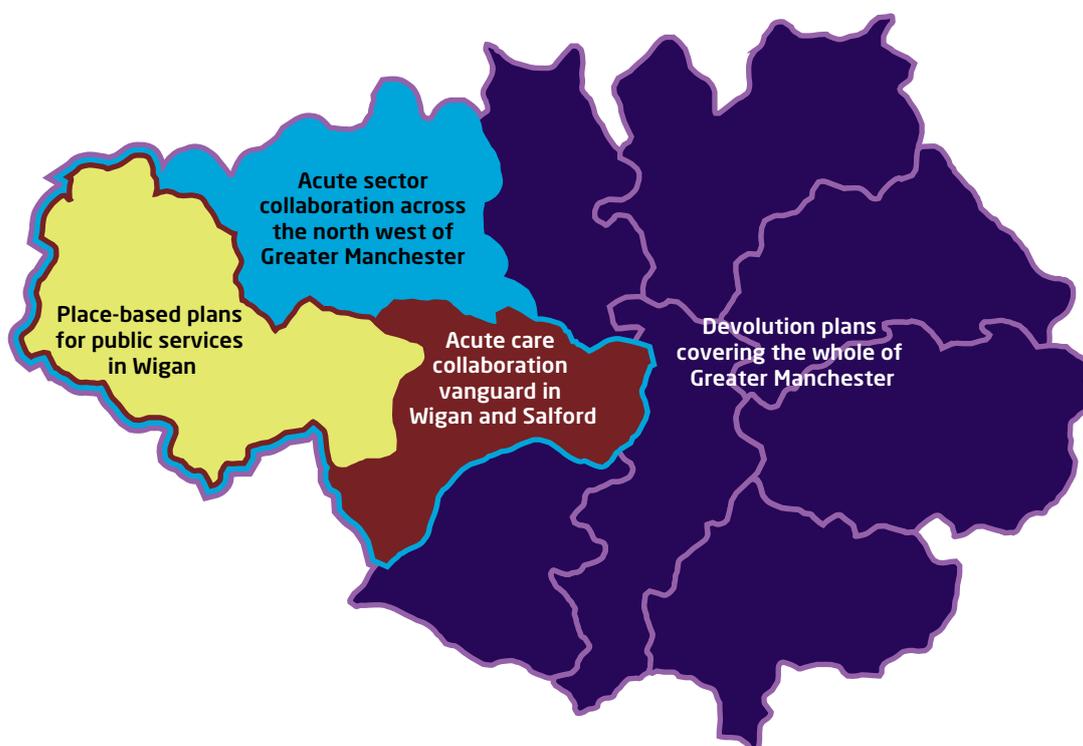


In many cases, NHS providers may find themselves involved in more than one system of care because of their role in providing services to patients drawn from a wide catchment area. Most obviously, major teaching hospitals provide a general hospital service to the local population and more specialised care both to the local population and to patients referred from other areas. This may mean that these hospitals, and indeed other providers working across boundaries, are members of more than one system of care, creating challenges around their capacity to be involved effectively in more than one system and potentially several.

One example to illustrate how different systems overlap is in Greater Manchester (see Figure 1). NHS organisations in Wigan, for example, will be involved in a number of different systems, including (and probably not limited to):

- devolution plans covering the whole of Greater Manchester
- plans for transforming public services in Wigan

**Figure 1** Overlapping systems





- the new acute care collaboration vanguard site across Wigan and Salford
- a wider acute sector collaboration across Wigan, Salford and Bolton as part of the Healthier Together programme in Greater Manchester.

Our argument centres on the case for providers to take the lead in establishing place-based systems of care – because of the need for providers to collaborate in developing new models of care that are clinically and financially sustainable – and leaves open the question of exactly how commissioners are involved alongside them. However, as we outline below, commissioners will need to be involved in working with providers to develop new models of commissioning and contracting to support the kinds of systems that we are describing.

Our argument also raises the much bigger question of how the commissioning function is organised. Successive attempts to develop commissioning in the NHS over the past 25 years have met with limited success, because commissioning health care is inherently complex wherever it has been attempted (Ham 2008). There are also specific challenges in England with the division of responsibilities between CCGs and NHS England, as well as between the NHS, local government and Public Health England. In view of the failure of commissioning to make a major impact, and the huge challenges facing the NHS, a quite different approach is needed in future. We explore this further in the final section of the paper, where we make the case for commissioning to be strategic and integrated in order to support the development of place-based systems of care.

### Develop a shared vision and objectives

Having defined the system in question and organisations involved, it falls to these organisations to agree their shared vision and objectives. A good example is the *Memorandum of understanding* developed in Greater Manchester (AGMA *et al* 2015), which includes a number of objectives that are summarised in the box below.

Objectives need to be tailored to the needs of different areas, reflecting the challenges that exist and the level of ambition of the partners. They should build on work done by commissioners and health and wellbeing boards in understanding the needs of the local population, as well as the knowledge of providers about local services.



### Objectives in Greater Manchester's *Memorandum of understanding*

- To improve the health and wellbeing of all of the residents of Greater Manchester (GM) from early age to the elderly, recognising that this will only be achieved with a focus on prevention of ill health and the promotion of wellbeing. We want to move from having some of the worst health outcomes to having some of the best.
- To close the health inequalities gap within GM and between GM and the rest of the United Kingdom faster.
- To deliver effective integrated health and social care across GM.
- To continue to redress the balance of care to move it closer to home where possible.
- To strengthen the focus on wellbeing, including greater focus on prevention and public health.
- To contribute to growth and to connect people to growth, eg supporting employment and early years services.
- To forge a partnership between the NHS, social care, universities and science and knowledge industries for the benefit of the population.

Source: AGMA *et al* 2015

In most cases, we would expect the focus to be initially on achieving the financial and clinical sustainability of local services as well as the development of new care models that cut across current organisational and service boundaries. Areas that have more experience in partnership working may choose to focus on the broader aim of improving population health and wellbeing from the outset. The vision and objectives underpinning systems of care will shape the partners that are involved and how they work together.

Agreeing objectives needs to be informed by the wants and needs of patients and the public. But in most health systems, we know very little about what patients and the public really want – and at the front lines of care the silent misdiagnosis of patients' preferences is widespread (Mulley *et al* 2012). Over time, systems of care must develop more meaningful and systematic ways of gathering and disseminating information about patients' preferences. This includes developing tools to continuously measure patients' preferences and acting on the information generated.



## Develop an appropriate governance structure

Having agreed objectives, the organisations involved need to develop an appropriate governance structure to enable them to collaborate and take decisions in the pursuit of these objectives. These arrangements must reflect existing accountabilities while also creating a basis for collective action. To do this successfully, they must be inclusive enough to ensure that those involved in delivering and receiving services are meaningfully involved in decision-making. The Nuka system of care in Alaska is one example where patients and the public have been actively involved in the governance of the local system (*see* the box below). The governance arrangements must also be strong enough to be able to co-ordinate the range of activities involved in meeting the group's objectives – something that is far easier said than done.

### **Involving patients and the public in governing the Nuka system of care**

The Southcentral Foundation is a non-profit health care organisation serving a population of around 65,000 Alaska Native and American Indian people in Southcentral Alaska, supporting the community through what is known as the Nuka system of care.

Nuka was developed in the late 1990s after legislation allowed Alaska Native people to take greater control over their health services. This fundamentally changed the community's role from 'recipients of services' in a top-down, paternalistic system to 'customer-owners' involved in designing and managing their health care (Gottlieb 2013).

The Southcentral Foundation involves patients and the public - its 'customer-owners' - in the governance of the health system in a number of different ways. This includes:

- having members of the public on its non-executive board
- involving members of the public on operating boards and advisory committees, which meet periodically with the senior leadership team to provide feedback
- involving members of the public in its strategic planning cycles, including through an annual gathering, an elders' council and planning sessions with village communities
- providing multiple opportunities for people to provide real-time feedback on services.

A forthcoming case study of the Nuka system argues that this model of 'customer-ownership' - set in context - has provided an effective form of governance in a system largely free from oversight from external bodies (Collins 2015b). Instead, services are governed based on a commitment from leaders and staff to serve their community and a commitment from the community to actively engage in the management of the system.



Experience with partnership boards of various kinds in the past offers a cautionary tale in ensuring that governance arrangements are fit for purpose and allow decisions to be made jointly, rather than descending into a talking shop or, even worse, failing to deliver the objectives. Analysis undertaken by the Audit Commission (2005), discussed further in section 3 of this paper, contains important lessons in this regard. Our experience suggests that the partners involved should be willing to be flexible about how governance arrangements evolve over time – for example, by including new members or rules.

It is also likely to mean the organisations involved agreeing to cede some of their own sovereignty as well as determining whether there are some issues over which they should retain the right to approve decisions taken collectively. Place-based systems are unlikely to be effective if they are merely a forum for discussion of issues of common concern without executive responsibilities. These and other issues need to be thought through at the outset to enable the right vehicles for collaboration to be established which are both binding and collective.

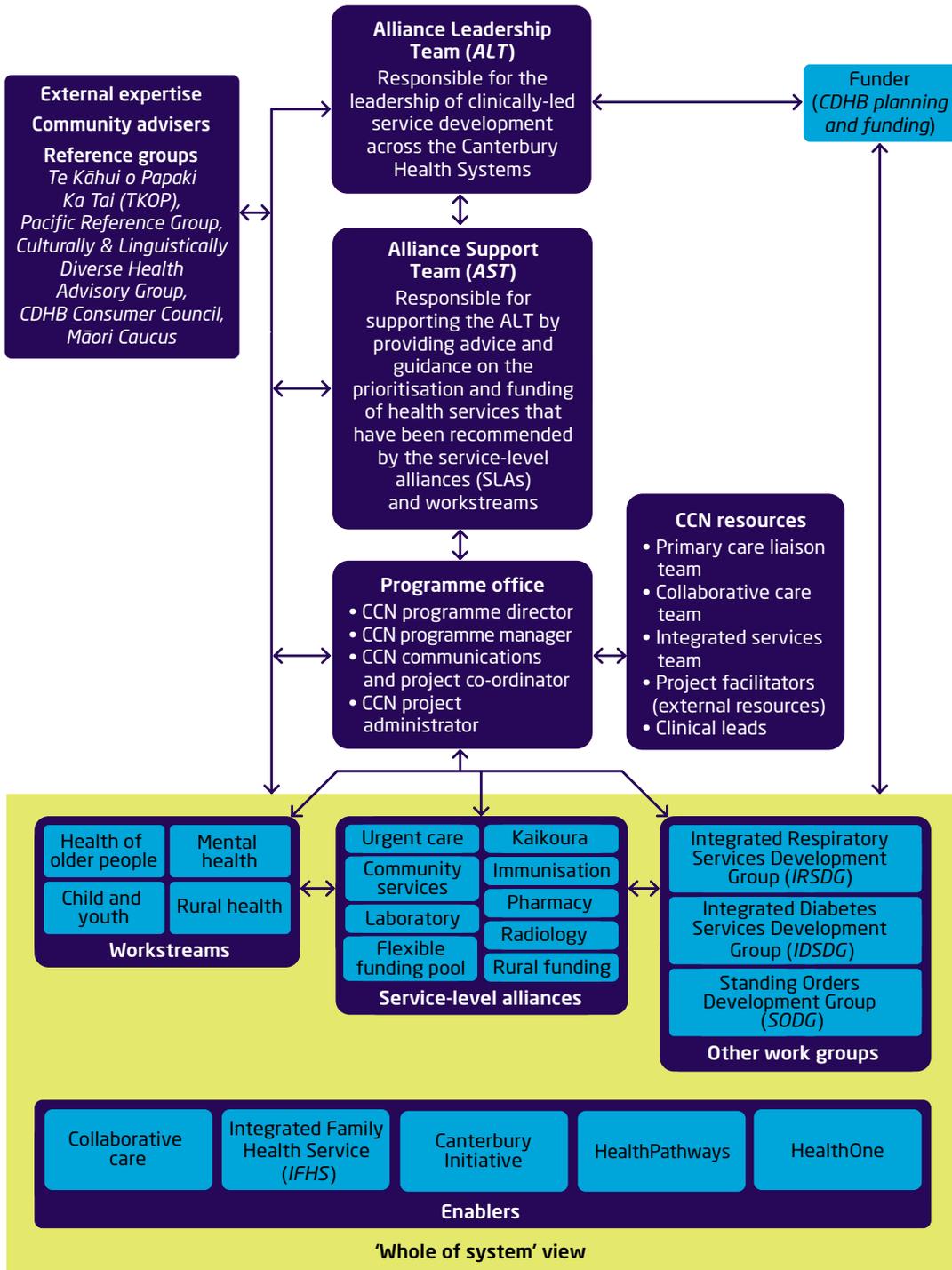
The Canterbury Clinical Network in New Zealand is one example where organisations involved in delivering health and care services have come together to lead clinical service improvements collectively across their local system. As Figure 2 outlines, the network is led by an alliance leadership team and supported by a dedicated alliance support team. Different work streams and service level alliances fit within a single governance structure, which is underpinned by a ‘one-system, one-budget’ approach. This approach has supported partners in Canterbury to develop more integrated health and care services which have allowed more care to be delivered out of hospital (Timmins and Ham 2013).

### Identify the right leaders and develop a new form of system leadership

Ensuring that the right leaders are involved in managing the system of care at the appropriate level of seniority, including chairs and board members where appropriate, is essential. Much will depend on the strength of the relationships between organisational leaders and the extent to which there is mutual trust and respect.

In many cases it will not be possible to secure agreement to even explore the issues discussed in this paper without a basic willingness to work together and an acknowledgement that collective action is needed to deal with the growing pressures

**Figure 2 Canterbury Clinical Network structure**



Source: Canterbury Clinical Network 2014



facing NHS and related services. In the absence of such agreement, the fortress mentality is likely to prevail with the attendant risks we identified at the beginning of this paper.

In some cases the leadership of experienced and credible individuals from outside the NHS may help to galvanise collaboration, as can be seen in the role of local authority leaders in Greater Manchester and in our work elsewhere.

The effectiveness of governance arrangements hinges on the ability of leaders to work collaboratively in an environment where they may have less authority than has often been the case in the past. This requires the development of a new kind of system leadership based on negotiation and influence rather than direction. Leadership of this kind is often best developed through teams rather than individuals, involving a guiding coalition taking responsibility to lead system-wide change.

Developing this kind of leadership may benefit from agreement on the values and behaviours to be used in taking collaboration forward. Statements of values and behaviours are of most use when they are developed jointly and used explicitly. This includes leaders holding each other to account for working in a way that is consistent with these values and behaviours, and giving each other permission to draw attention to examples where this does not happen. Again, there is experience in other parts of the public sector on which to draw in developing system leadership (Timmins 2015).

Leadership needs to extend right through the organisations involved in place-based systems of care and we would emphasise in particular the role of clinical leaders in developing new care models that span organisational and service boundaries. System leadership that is not underpinned by clinical leadership and the engagement of frontline clinical teams will not deliver the benefits we have argued for.

### Agree how conflicts will be resolved

Governance arrangements also need to allow for the possibility of conflict between the organisations involved and give direction on how this will be handled locally. Agreeing how conflicts will be resolved within the system of care is therefore essential. There should be an emphasis on informal mechanisms such as mediation



rather than resorting to legal action. Wherever possible, conflict should be viewed as a healthy reflection of the state of collaborative working and the ability of the organisations involved to disagree and move on. At the same time, partners should be clear about the consequences for organisations that fail to play by the agreed rules and behaviours of the system. This, again, is where statements of values and behaviours are likely to be useful.

### Develop a sustainable financing model

Conflicts are possible in many areas but especially in relation to how resources are used and distributed. Creating a sustainable financing model for the system of care is not simple and requires commissioners and providers to work together. We have argued elsewhere that this means taking a new approach to paying for across three different levels (Ham and Alderwick 2015).

First, local partners need to agree the collective resources available to meet the objectives of the system. For example, if the objective is to implement radically different models of health and social care for the whole of the local population, this might involve pooling resources currently spent on health and social care services in a local area. In practice, this is likely to mean commissioners of health services and local authorities working together to pool their budgets and commission services jointly.

Second, commissioners must develop new ways of contracting with providers to align incentives behind the system's objectives. Our proposed approach is for commissioners of health and social care to pool resources and create a single, capitated budget covering all care for the local population, for providers to manage under a contract extending over a number of years. A proportion of payments made to providers within the budget should be linked to the delivery of a common set of outcomes, developed through engagement with people using services about what matters to them. Rather than an approach focused on single disease groups, a population approach recognises that people's needs are multiple and overlapping and avoids creating new silos to replace the old ones.

There are a range of different contracting vehicles that could be used to support this type of approach. Examples include prime contracts and alliance contracts, both of which are being explored and tested in various parts of the NHS in England,



as well as in other countries (Addicott 2014). In stylised terms, prime contracts involve payments being made to single providers, who in effect become *de-facto* commissioners, responsible for managing the budget, co-ordinating the supply chain and making payments to other providers. Under alliance contracts there is no lead provider, as commissioners and providers enter into a single contract to share the risk and responsibility for meeting a common set of outcomes, relying on internal governance arrangements to manage relationships and the delivery of care. These models are best seen as ideal types, with a range of versions and variants in between.

Third, providers of care within the system will need to agree how they allocate resources and share costs, risks and rewards. This might involve developing multilateral risk-sharing agreements that set out how resources will flow between providers in different scenarios to support the system's objectives. For example, partners could agree what happens if activity for one provider grows above an agreed threshold to ensure that care in other areas is not damaged as a result. They could also agree how any savings made from reductions in activity in certain areas will be shared between providers in the system to reinvest in service changes. More important than the technical detail, this will require strong relationships between local leaders willing to work together rather than compete for resources.

The challenge for the NHS in developing more sustainable financing models is the growing imbalance between providers' incomes and spending – an imbalance that in the first quarter of this financial year (April to June 2015) amounted to £930 million for NHS trusts and foundation trusts (Monitor 2015; NHS Trust Development Authority 2015). This is something that requires national action as well as the local action that we describe here.

### Create a dedicated team

To make these kinds of arrangements work, a dedicated team should be established to support the work of the system and act on behalf of leaders in implementing decisions. This team must have authorisation to drive the work of the system from its most senior leaders. Evidence from other sectors tells us that this is best done by a new team able to focus solely on the work of the system, rather than a team made up of people simultaneously trying to manage the ongoing operations of individual organisations (Govindarajan and Trimble 2010). In the absence of such support,



there is the ever-present risk that plans will not be executed, resulting in frustration and loss of commitment.

Of course, new ideas and ways of doing things will only make a difference if they can be successfully implemented across the organisations involved, which means that the dedicated team should not work independently of others. Doing this will require people who are able to make connections between different parts of the system to help make change happen ([Battilana and Casciaro 2012](#)).

### Develop systems within systems

In working to meet common objectives and particularly when systems of care evolve, it is likely that different partnerships will emerge within and also across place-based systems to tackle particular issues of concern. For example, one group of partners might work together to reduce demand on urgent and emergency care services, another might focus on the interventions needed to help reduce obesity across the population, while another might focus specifically on improving care for people at the end of life – and some might work on all three.

This means that systems of care must develop ‘systems within systems’ to focus on different aspects of their objectives, drawing on skills and services from across the community. The important task is to ensure that activities of different groups form part of a coherent, mutually reinforcing approach, rather than becoming a disjointed set of initiatives.

### Develop a single set of measures

Finally, a system of care must decide on a single set of measures to underpin its shared objectives. This is likely to involve agreeing a small set of metrics to assess the overall performance of the system, as well as how these metrics will be collected and reported – including to the public. A larger set of metrics should also be collected to allow partners to understand how they are contributing to the overall goals of the system and identify areas for improvement (similar to the approach set out in [Ham et al 2015b](#)).

As well as routinely collected performance data, this should include measures to test whether the system is behaving in a way that aligns with its agreed values and



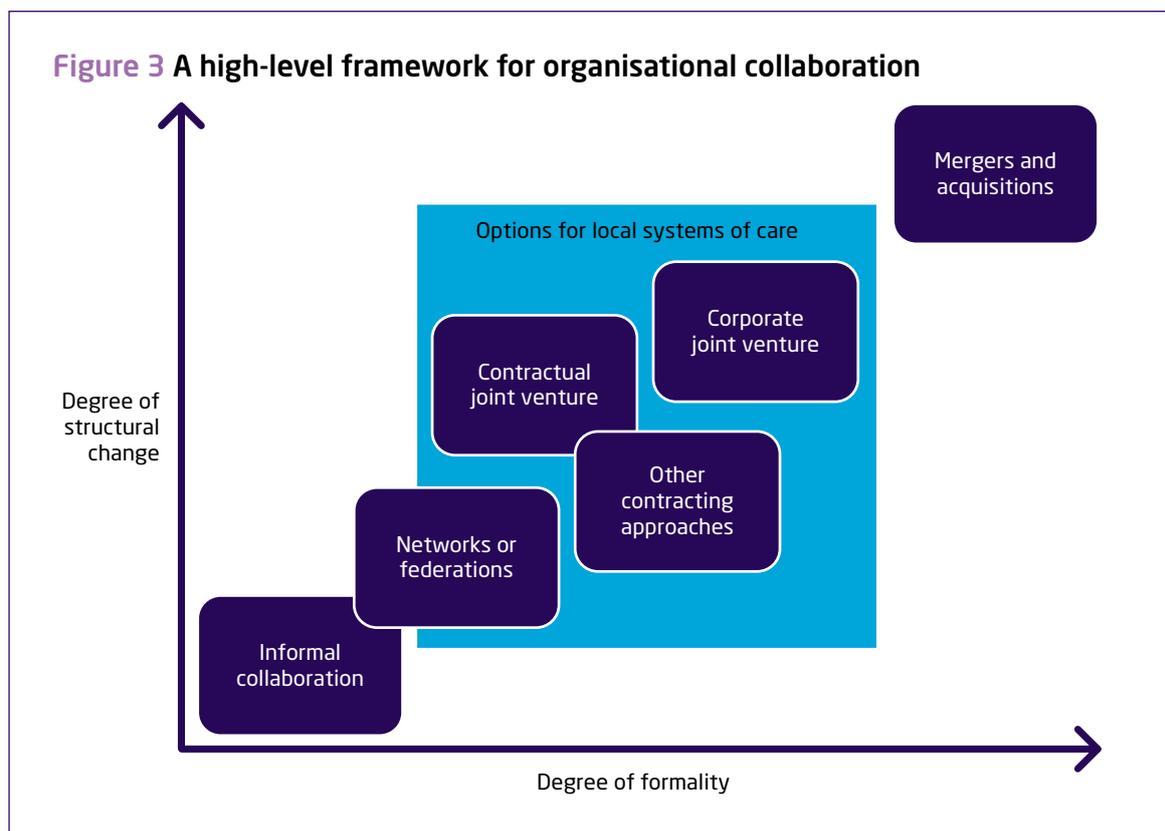
behaviours. For example, measures such as IntegRATE developed by researchers in Dartmouth College in the United States can be used to measure how well teams are collaborating to deliver more integrated services to their patients (Elwyn *et al* 2015), while tools such as CollaboRATE can be used to measure patient engagement and shared decision-making in routine practice ([www.collaboratescore.org/](http://www.collaboratescore.org/)).

The experience of high-performing health care systems in other countries illustrates the value of a sustained commitment to quality improvement based on clarity of the system's goals and systematic measurement of progress towards them (Ham 2014). This should be reinforced by an explicit quality improvement methodology that is consistently applied.

One of the risks in developing systems of care is that of adding further complexity to an already complex system. While this cannot be avoided entirely, the design of governance arrangements needs to be done in a way that minimises transaction costs and seeks to keep these arrangements as simple as possible.

## 3 Options for collaboration

Various options exist for formalising how organisations will work together in place-based systems of care. A helpful starting point is the high-level framework illustrated in Figure 3, which sets out a spectrum of organisational options, ranging from informal collaborations at one extreme, to formal mergers and acquisitions at the other. For this we have adapted and revised a similar framework set out in the Dalton review (Dalton 2014, p 20).



Place-based systems of care sit somewhere in the middle of the two extremes of the spectrum and may be established as either a contractual or corporate form of collaboration (Hempsons 2015). An example of a *corporate* collaboration would be the creation of a corporate joint venture established as a new legal entity, which could take a variety of different forms, including:



- companies limited by shares
- limited liability partnerships
- community interest companies.

Developing new forms of corporate collaboration in the existing policy and regulatory environment in the NHS is not always simple. For example, it is important to note that current statutory powers for non-foundation trust providers limit the use of corporate vehicles such as limited companies and limited liability partnerships. It is also worth noting that collaborations involving limited liability partnerships are unable to hold contracts for essential primary care services unless GPs are willing to opt out of their General Medical Services/Personal Medical Services contracts. Various ‘workarounds’ exist to achieve similar goals, but the rules are not straightforward.

Examples of *contractual* options include prime contracts, alliance contracts and contractual joint ventures, all of which are currently being developed in different parts of England (Addicott 2014).

The challenges in establishing and sustaining more formal collaborations such as these should not be underestimated. In creating a new legal entity, for example, the organisations involved will be sharing control and therefore surrendering some of their own autonomy. In the right circumstances, this has the potential to achieve more than through organisations working independently but there is always a risk that a new entity will acquire a life of its own and result in friction between the organisations involved.

Whatever option for collaboration is pursued, it is vital that the partners involved agree how decisions will be made, how they will be held to account, how different stakeholders will participate in the running of the system, and so on. The same applies if the basis for collaboration is contractual, as networks of providers will need to develop appropriate governance structures to manage the contract and work together to implement new models of care (Addicott 2014).

To make these points is to emphasise the detailed work needed to put in place the right arrangements to make a reality of systems of care. As this happens, it will be



important not to focus on the legal and technical aspects to the exclusion of the relationships on which effective collaboration ultimately depends.

## Networks

Clinical networks are located towards the less formal end of the collaborations identified in Figure 3 and there is previous experience from within the NHS on how these have fared. A major research review published in 2010 described different types of networks in health care and summarised evidence on their experience (Ferlie *et al* 2010). The authors' empirical work in eight networks – including managed cancer networks, sexual health networks, older people's networks and genetics knowledge parks – highlighted a number of advantages and disadvantages of organising in this kind of way. Advantages included the potential to:

- address 'wicked problems' in health policy that require action across sectors and organisations
- secure high levels of clinical engagement
- implement national policy goals or major service reconfigurations within localities.

On the other side of the balance sheet, a number of disadvantages were identified in the networks that were studied, including:

- a degeneration into 'talking shops', with many meetings and little output to show for it
- a weak focus, which could be helped by clear targets or milestones
- difficulty in maintaining momentum without dedicated resources
- challenges in performance managing the network
- high transaction costs and few short-term wins



- the potential to become dominated by certain professional groups
- the need for skilled, well-resourced management to be effective.

These lessons from past experience emphasise some of the potential challenges that come with working in networks, as well as pointers for how they could be avoided – for example, through ensuring that networks have enough resources and dedicated support to run effectively, as well as leaders able to mix the ‘hard’ and ‘soft’ management styles needed to work effectively across systems.

Evidence reviewed by *6 et al* (2006) similarly emphasises the need to strike a balance in how networks in health care are managed. While tight control in more hierarchical networks risks demotivating professionals and creating friction among partners, networks that are too loosely regulated risk ‘professional capture’ by some groups – and in some cases may simply lead to the maintenance of the status quo. This in turn emphasises the need to recognise that not all networks are the same: they can be more or less tightly regulated by rules and institutions, and they can be more or less integrated in terms of the relationships between partners (*6 et al* 2006). In practice, network leaders will likely need to navigate a course between these extremes to be successful.

### Public sector partnerships

Looking at the broad spectrum of partnership models used by organisations in the public sector back in 2005, the Audit Commission found that partnership working takes up a lot of time and other resources, and can extract value as well as add it (**Audit Commission 2005**). It also found that problems arose when governance and accountability were weak, and leadership, decision-making, scrutiny, and systems and processes were under-developed. The Audit Commission argued that partners need clarity on governance – specifically, agreement on the purpose, membership and accountabilities of the partnership. This requires a governing document that clarifies roles and relationships and helps to build goodwill and trust. Part of the purpose of such a document is to set out accountabilities both internally between the partners and externally to the public.

More recent initiatives to develop partnership working in public services include the Total Place and Whole Place Community Budget programmes, established under



both Labour and coalition governments (*see* National Audit Office 2013; [Humphries and Gregory 2010](#)). These initiatives were motivated by many of the same concerns that lie behind this paper – in particular that collaboration across public services would deliver better value for citizens than organisations working independently of each other. In practice, they typically involved collaborations between local authorities and other partners based on information sharing and joint needs analysis of the populations served, rather than shared decision-making and more formal collaborations.

This kind of collaboration brought some benefits, but there were obvious limits to their impact on the use of resources and outcomes in the areas involved (House of Commons Communities and Local Government Committee 2013; National Audit Office 2013). Current interest in devolution in Greater Manchester and other areas is in some respects the successor to these initiatives and it remains to be seen whether this will be more effective.

### Experience in Scotland

The Scottish government has put in place a legislative framework to support integration between health and social care commissioning and delivery. An important difference from England is that the NHS in Scotland has a much simpler structure in which place-based health boards are already responsible for both commissioning and providing health services in their areas. These boards are required either to adopt a lead agency model with relevant local authorities or to create a joint integration board to which functions and resources are delegated. The joint integration board is a legal entity in its own right, established under relevant legislation.

These arrangements have only just been established and there is little evidence as yet on how effectively they are working. In principle, they could be used in England with adaptation to support the place-based systems of care we have argued for, if national bodies think it necessary to mandate partnership working instead of allowing it to evolve from the bottom up. An alternative would be for the government to legislate to create options for place-based collaborations without requiring their use.



## Emerging examples in the NHS

In our work we are aware of steps already being taken in some parts of England to establish place-based systems of care on a more formal basis. In York, for example, providers have formed an out-of-hospital provider alliance involving the foundation trust, two GP federations, local authorities and the York CVS. At the time of writing, the alliance operates under a non-legally binding statement of principles.

In Solihull, the main public sector organisations have formed a partnership called ‘Solihull Together for better lives’, with a shared vision of:

- supporting economic growth to provide long-term stability and quality jobs
- making communities stronger
- improving people’s health and wellbeing.

The core group includes the local authority, Solihull CCG, Birmingham and Solihull Mental Health NHS Foundation Trust, Heart of England NHS Foundation Trust and West Midlands Police, who also work closely with primary care providers, third sector groups, patient representatives, the fire service and others across the local area. A compact has been agreed defining the group’s objectives and how they will work together, and a single governance structure has been developed to lead their work. Dedicated programme management support has been funded jointly, and chief executive officers and finance directors of each organisation meet regularly to work out how financial costs and risks will be shared across the group to meet their objectives.

Another emerging example can be found on the Isle of Wight, where NHS organisations and the local authority are changing the way that they are organised as part of their work as a primary and acute care system vanguard site known as ‘My Life A Full Life’. Working under the health and wellbeing board, a joint commissioning board and a joint provider board have been established, together with a board that provides overall leadership of the programme. Emphasis has been placed on developing system leadership and a ‘one island £’, echoing the approach used in Canterbury, New Zealand, which was based on the vision of there being ‘one system, one budget’ (Timmins and Ham 2013).



The vanguard site is investing in leadership and organisational development as part of its work.

In Morecambe Bay, providers and commissioners are working with local authorities and GP federations to develop what they are calling an ‘accountable care system’. This builds on a recent history of joint working and selection as one of the primary and acute care system vanguards. The aim is to commission and provide health and care services around the needs of the population, with providers working together under a capitated budget.

There are some similarities between this approach and work in Northumberland – another area that has been selected as a primary and acute care system vanguard – where there are plans to establish an accountable care organisation (ACO). This builds on longstanding efforts to integrate services in Northumberland, in particular between the foundation trust which provides acute, community and adult social care services and local GP federations (*see Naylor et al 2015*). An important difference from Morecambe Bay is that the CCG will not be directly involved in the special purpose vehicle being established to develop the ACO.

Sir Robert Naylor, chief executive of University College London Hospitals NHS Foundation Trust, has argued that ACO-type systems could play a major part in ensuring the sustainability of NHS services in future. In his view, ACOs would involve collaboration between providers working under a capitated budget and focused on the health of the population served. Under this arrangement, there would be an incentive to invest in prevention and services outside hospitals to reduce the use of expensive specialist care. Naylor has also questioned the need for commissioning in its present form if ACOs do emerge (Barnes 2015).

Many others, including the Secretary of State for Health, have also drawn parallels between ACOs in the United States and the kind of changes needed in the NHS in England.

### Accountable care organisations

A range of approaches to collaboration between organisations are being explored by ACOs in the United States. The first national survey of ACOs in 2012 and 2013 highlighted the diversity of organisational models being developed to meet ACOs’



aim of improving quality and reducing costs – including hospital-led ACOs, physician-led ACOs and a variety of hybrid models in between (Colla *et al* 2014).

Whatever form ACOs take, researchers have emphasised the critical role of clinical leadership if they are going to be able to fundamentally change the way that care is delivered for their local populations. And just like the experience of partnership working in the NHS, emerging ACOs have found it difficult to develop governance arrangements that are able to hold partners to account as a collective and meaningfully affect people's behaviour (Addicott and Shortell 2014).

In thinking about how ACOs might develop in England, it is important to remember that early evidence on their impact in the United States is both limited and mixed (Shortell *et al* 2015). We summarise early evidence of the impact of ACOs on quality and cost in the box below. Much more is known about the various forerunners of ACOs, including established integrated systems such as Geisinger, Group Health, Intermountain Healthcare and Kaiser Permanente (for example, *see Curry and Ham 2010*). A number of lessons can be drawn from the experience of these systems and that of ACOs, including allowing sufficient time for new care models to evolve and mature. The challenge this presents for the NHS is that time is in short supply.

### Early evidence from accountable care organisations in the United States

ACOs in the United States involve groups of providers taking responsibility for providing all care for a given population within a capitated budget, under a contractual arrangement with an insurer. Broadly speaking, there are three types of ACOs (Shortell *et al* 2014):

- organisations with integrated delivery systems offering a relatively large number of services
- smaller physician-led medical groups offering a smaller number of services
- hybrid groups led by a combination of hospitals, physicians and health centres that offer an intermediate range of services.

In 2014 there were more than 750 ACOs in the United States serving around 20 million people (Muhlestein 2014). Early evidence about their impact on cost and quality is mixed. Results for the second year of the Medicare Pioneer and Shared Savings ACOs report savings of more than US\$372 million and mean improvements on measures of quality and



patient experience ([Centers for Medicare and Medicaid Services 2014](#)). On the flipside, it is worth recognising that most of these savings were made by a small number of high-performing ACOs and some Pioneer ACOs chose to drop out of the programme.

The best results have been achieved by groups operating under Blue Cross Blue Shield's Alternative Quality Contract in Massachusetts. Providers are given a capitated budget linked to incentives to manage costs and improve quality together. Evaluation after four years showed that providers operating under an Alternative Quality Contract compared with a control group experienced lower spending growth (equivalent to a saving of around 7 per cent) and greater improvements in quality of care across a number of measures (Song *et al* 2014).



## 4 Implications for national bodies and policy-makers

While the main responsibility for developing place-based systems of care rests with NHS organisations and their partners, national bodies have an important part to play in removing obstacles to their development and offering advice and support. Issues here include:

- extending the approach used in the success regime in which NHS England, Monitor and the NHS Trust Development Authority, working with the Care Quality Commission, adopt a co-ordinated approach in their interventions in local systems
- ensuring that rules on procurement and competition do not create barriers to the emergence and functioning of place-based systems of care
- supporting innovations in commissioning and contracting, including prime contract and alliance contract models
- encouraging innovations in payment systems such as capitated budgets linked to the delivery of agreed outcomes of care
- supporting commissioners within the NHS and between the NHS and local government to pool their budgets and commission services jointly
- putting in place an integrated performance assessment framework using metrics that reflect whole-system performance
- identifying and sharing innovations in the development of place-based systems of care to avoid wasteful duplication of effort in different areas
- supporting areas that are testing out new ways of working to work with, and learn from, each other



- providing legal and technical advice on the organisational forms that are available to make a reality of partnership working
- making it easy for providers to amend their licences with Monitor and the Care Quality Commission to support local system working
- allowing greater flexibility for providers in establishing new corporate vehicles to support joint working
- considering whether to follow the approach used in Scotland where the government has created a legislative framework to enable partnership working.

### A new form of strategic commissioning

Returning to a point made earlier in this paper, place-based systems of care require fundamental changes in the role of commissioners.

In our analysis of the challenges facing health services in London ([Ham et al 2013](#)), we argued the case for a London-wide strategic commissioner alongside a small number of provider networks to tackle the growing financial and service pressures in the capital. In the two years that have intervened since that analysis, we have become even more convinced that the fragmentation of commissioning and provision will not deliver the changes that are needed, and that there is increasing urgency in putting in place an alternative. Hence the ideas set out in this paper.

Drawing on the experience of the Veterans Health Administration in the United States in the 1990s (*see* the box below), we have suggested that commissioning should be seen primarily as a strategic function that brings together scarce expertise rather than diffusing it to a large number of small organisations that struggle to negotiate on equal terms with providers ([Ham et al 2013](#)). We would add that commissioning also needs to be integrated, including between the NHS and social care, to enable greater collaboration between providers. Options for doing so have been outlined in a recent report from The King's Fund ([Humphries and Wenzel 2015](#)) and are integral to the plans for devolution under development in Greater Manchester.

Strategic commissioning as we understand it encompasses the funding and planning of services as well as holding providers to account for the delivery of agreed



## Parallels with the transformation of the Veterans Health Administration in the 1990s

The ideas set out in this paper contain important parallels with the experience of the Veterans Health Administration (VA) in the United States, which underwent a major transformation in the 1990s. The VA's experience lends strong support to our argument for place-based systems of care, as these systems have strong similarities with the regionally based integrated service networks that helped to transform the delivery of care in the VA during its transformation.

Networks in the VA received a population-based capitated budget to deliver care and had the flexibility to use this on hospitals or other services based on their assessment of local needs (see the summary in [Curry and Ham 2010](#)). The VA's headquarters acted as the strategic funder and planner of services from these service networks and reviewed their performance against targets on a regular basis. Many of these targets related to the quality and outcomes of care.

This organisational model was one of the ingredients behind the transformation of the VA which over a period of five years moved from being a system on the brink of failure ('special measures' in NHS parlance) to an organisation widely admired for the quality of care it delivered. The VA also invested in the development of its leaders to support the implementation of the model.

By extension, place-based systems of care would bring together NHS foundation trusts, NHS trusts and other providers in an area - including community-based groups, federations of general practices and third sector providers - under the leadership of experienced clinicians and managers. At a time when there is growing evidence of difficulties in recruiting leaders to senior NHS roles ([Janjua 2014](#)), this would be a way of using the expertise that does exist as effectively as possible.

Working within the framework of locally defined governance arrangements, system leaders would have the latitude to reconfigure services as happened in the VA, where there was a substantial reduction in hospital capacity and a major investment in out-of-hospital care - both in people's homes and through strengthening primary care (see [Ashton et al 2003](#)). As the *HSJ's* commission on leadership argued recently ([HSJ 2015](#)), this will require a streamlining and simplification of current arrangements for consulting on service changes to avoid necessary decisions being delayed or derailed.

In drawing on the experience of the VA, we are not suggesting that the NHS can simply extrapolate from the approach it adopted without modification. We are arguing that the core ingredients of place-based systems of care involving relevant providers, strategic commissioning, capitated budgets and providers being held to account for delivery against defined outcomes are what matters.



outcomes of care. We have argued that this should be done by commissioners developing capitated budgets covering the whole of a population's care, for groups of providers to collectively manage over a number of years (*see pp 20–22*). Commissioners would define clear outcomes for providers to deliver within the budget, rather than being involved in multiple transactional relationships and the day-to-day performance management of a complex array of contracts.

The box below summarises the key points of what this means for commissioning in the NHS.

### What does our proposed approach mean for commissioning in the NHS?

- Commissioners taking a strategic role, defining outcomes and measuring the performance of the system as a whole.
- Commissioners in many parts of England working together across larger geographies than they do today.
- Health and social care commissioners pooling budgets and working together to commission services jointly.
- Commissioners developing capitated budgets covering the whole of a population's care, for local providers to collectively manage.
- Commissioners setting clear outcomes expected for providers to deliver using the resources available.
- Commissioners negotiating longer-term contracts with providers in order to reduce transaction costs.
- Commissioners doing less detailed contract negotiation and performance management of multiple providers.
- The existing boundary between commissioning and provision becoming increasingly blurred, with many traditional commissioning responsibilities falling under the remit of systems of care.

The case for strategic commissioning rests on the failure of commissioning to make a major impact in the NHS ([Mays \*et al\* 2011](#); [Smith \*et al\* 2004](#); [Le Grand \*et al\* 1998](#)) and the need to use scarce expertise as effectively as possible, not least to ensure that place-based provider collaborations are mirrored by a level of commissioning expertise that it is simply not possible to provide in more than 200 CCGs.



Strategic commissioning will require thoughtful evolution towards a system in which the clinical expertise and local knowledge of CCGs are retained and where NHS commissioning is based on footprints much bigger than those typically covered by CCGs today. The ability of CCGs in north-west London and Greater Manchester to collaborate over planning and working towards major reconfigurations of services illustrates one way forward, although these examples remain the exception rather than the rule. Recent developments in Staffordshire where six CCGs have agreed to work together in a regional commissioning group, alongside local authorities and NHS England, are a practical example of how this is being addressed (Renaud-Komiya 2015).

Strategic commissioning is quite different from how commissioning is understood and practised in the NHS today. It will no longer entail detailed contract specification, negotiation and monitoring, and the routine use of tendering. Instead, the focus will be on defining and measuring outcomes, putting in place capitated budgets with appropriate incentives for providers to deliver these outcomes, and using long-term contracts (for example, alliance contracts as used in New Zealand) extending over five to ten years. This will reduce transaction costs and free up some resources to invest in improving health and care.

We would add that place-based systems of care are likely to blur the distinction between commissioning and provision, as is beginning to happen in some of the new care models being developed under the *NHS five year forward view* (NHS England *et al* 2014). This means that systems of care will themselves take on some commissioning functions as they work to deliver the outcomes agreed with strategic commissioners. In practice, systems of care will need to decide how to use the budgets available to them, and the contracting and incentives required to ensure effective collaboration between providers.



## 5 Conclusion

Making these ideas happen will be neither simple nor easy, but in our view the direction that we have set out in the paper is far preferable to the alternative of the fortress mentality, which risks descending into a war of all against all, or another major restructuring of the NHS. Finding intelligent ways of making the existing system work better through rapid evolution, with the emphasis on locally devised arrangements within the broad framework we have described, is where we believe that attention now needs to be focused.

National bodies need to play their part in this process by both removing barriers to place-based systems of care and providing support to local leaders where there is a willingness to work in this way. The chief executive of NHS England, Simon Stevens, set out his thinking on how this might be done in a speech at The King's Fund in October 2015 ([Ham 2015](#)). He suggested that increases in NHS funding in 2016/17 would be held back until NHS organisations came forward with agreed plans for improving health and care in their areas.

If implemented well, this proposal could help to galvanise the leaders of NHS organisations to come together in place-based systems where this is not already happening, and it could accelerate progress where it is. There are, of course, many challenges in making Stevens' proposal work, including agreeing the boundaries of the systems that are bidding for funding where this is not clear, and securing agreement among organisational leaders on plans for the use of funding increases. Now is the time for these challenges to be grasped with the urgency demanded by the huge challenges facing the NHS.



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**Chris Ham** took up his post as Chief Executive of The King's Fund in April 2010. He was Professor of Health Policy and Management at the University of Birmingham between 1992 and 2014 and Director of the Health Services Management Centre at the university between 1993 and 2000. From 2000 to 2004 he was seconded to the Department of Health, where he was Director of the Strategy Unit, working with ministers on NHS reform.

Chris has advised the World Health Organization and the World Bank and has served as a consultant on health care reform to governments in a number of countries. He is an honorary fellow of the Royal College of Physicians of London and of the Royal College of General Practitioners, and a companion of the Institute of Healthcare Management. He is a founder fellow of the Academy of Medical Sciences.

Chris was a governor and then a non-executive director of the Heart of England NHS Foundation Trust between 2007 and 2010. He has also served as a governor of the Canadian Health Services Research Foundation and the Health Foundation and as a member of the advisory board of the Institute of Health Services and Policy Research of the Canadian Institutes of Health Research.

Chris is the author of 20 books and numerous articles about health policy and management. He is currently Emeritus Professor at the University of Birmingham and an Honorary Professor at the London School of Hygiene & Tropical Medicine. He was awarded a CBE in 2004 and an honorary doctorate by the University of Kent in 2012. He was appointed Deputy Lieutenant of the West Midlands in 2013.

**Hugh Alderwick** joined The King's Fund in 2014 as Senior Policy Assistant to Chris Ham. Since joining The King's Fund, Hugh has published work on NHS reform, integrated care and population health, and opportunities for the NHS to improve value for money.

Before he joined The King's Fund, Hugh worked as a management consultant in PricewaterhouseCoopers' (PwC) health team. At PwC, Hugh provided research,



analysis and support to a range of local and national organisations on projects focusing on strategy and policy.

Hugh was also seconded from PwC to work on Sir John Oldham's Independent Commission on whole-person care, which reported to the Labour Party at the beginning of 2014. The Commission looked at how health and care services can be more closely aligned to deliver integrated services meeting the whole of people's needs.



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The NHS in England is facing growing financial and service pressures at a time of rising demand. It is seeking to tackle these challenges in the context of organisational arrangements that are more complex and fragmented than at any time in its history. How can these arrangements be adapted and made fit for purpose while avoiding another damaging reorganisation?

*Place-based systems of care: a way forward for the NHS in England* proposes a new approach. It looks at how the NHS can move away from the prevailing 'fortress mentality', whereby each NHS organisation acts to secure its own individual interests and future regardless of the impact on others, to place-based 'systems of care', whereby NHS organisations and services work together to address the challenges they collectively face.

The paper:

- sets out 10 principles to guide the development of place-based systems of care covering, for example, governance arrangements, financing and objectives
- examines the different options for collaboration between organisations to manage collective resources
- highlights the important role that national bodies and policy-makers have in removing obstacles to the development of systems of care and offering advice and support
- emphasises that commissioning needs to be strategic and integrated to enable greater collaboration between providers.

The main argument of the paper is that collaboration through place-based systems of care offers the best opportunity for NHS organisations to tackle the growing challenges that they are faced with and to improve the health and wellbeing of the populations they serve.

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