The burden of hope: place-based care and systems working

Guest blog by David Rogers, Chair, North Staffordshire Combined Healthcare NHS Trust

For the last six years I have chaired a small mental health trust in Staffordshire. Small trusts with small budgets can do little directly to impact accumulated financial deficits, but they can contribute talent to help drive the collective reshaping of resources so as to impact the health inequalities which beset us, all the more as a consequence of Covid.

That has been our primary strategic intent, and these observations are drawn from that process – a process which has accelerated rapidly, not because of government or NHSEI direction, but because of the experience of Covid. Change has been freed from its shackles and collaboration recognised as essential and natural.

There can be no doubt that a commitment to place-based care will come to nought if it does not have the whole-hearted involvement of local authorities. Any serious attempt to improve health (and not just treat the sick) must start with data about the health of the communities we are responsible for.

A vision for a better future must be built on an honest and agreed assessment of our existing condition. Public health, within local authorities, properly resourced and integrated, can and must assemble the data we need to form the foundation of our planning. Systems, whether they are ICPs or ICSs, must not be seen as NHS entities. Local authorities must not be 'invited' to join, they must be integral, right from the start.

It's not just that we need data to plan healthcare efficiently and effectively, it's that we need data to expose inequalities, to set priorities and to identify all the stakeholders who need to be involved in formulating and achieving a vision which is supported by our communities. All those well-rehearsed determinants need to be brought into play.

Only when we have developed and agreed the vision will we have the function of the system, and only then can we be confident about involvement and form. Our NHS culture, shaped of late through choice and competition, has a tendency to station the cart of form before the horse of function.

As well as data, there is another prerequisite for this process, and that is the effective collaboration of disparate stakeholders. Agreeing on a collective vision, and the main building blocks to achieve that vision, relies on a set of relationships between inclusive partners, built on trust, understanding and empathy.

Those relationships need to be grown, but Covid has been beneficial with all this, rapidly throwing together leaders and organisations to deal with the various crises as they were recognised. The joint support teams for care homes are just one example, but vaccination coordination is another. We need to start attending each other's board/committee meetings – yes, including the 'private' ones. If we are able to see and understand problems from other's perspectives, we can start to be empathetic and supportive.

One can imagine all this going really well, until we

get to the money. There are some parts of the country in which system-working, along the lines I have outlined, started years ago and has advanced impressively well, but suddenly screeched to a halt when it came to consolidating the funding flow. The problem must not be underestimated: the financial regimes of stakeholders and their relative insecurity and inadequacy need to be recognised from the outset, and not parked in the 'too difficult' pile until the later part of the process. Understanding and empathy must be founding aspects of collaboration, however daunting the prospect.

One more thing: accountability. In the NHS trust world, we have embedded accountability to regulators, and that's not surprising, given the need to demonstrate to government that taxpayers' money is being well-spent. But in the world of population health a new accountability becomes significant – to the communities we serve. We need to build governance structures that recognise local accountability, and we need to learn a new language in which to communicate to those communities. This is where our colleagues in local authorities can help us, in terms of both structures and language.

And as we invent governance for systems, let us not forget the merits we have developed of non-executive influence. There is a danger that all this change can become executive-driven, and we do need to retain a function of oversight, drawn from our communities and endowed with wider experience.

It was the splendid Rachel Clarke in her recent book on the pandemic who reminded us of the etymology of the word apocalypse – which has been applied to the Covid experience. The original meaning was the unveiling of a new future, and is that not where we now stand, imagining and planning a new future for health and healthcare?

There is a sense that we live in the most challenging, but also the most encouraging of times. The opportunity to shape and secure that better future is now in our hands. We carry the burden of hope.