

# Place-based approaches and the NHS

## Lessons from Total Place

### Seminar Highlights

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# Contents

<b>Introduction</b>	<b>3</b>
Richard Humphries	
<b>Integrated working: breaking down public service barriers</b>	<b>7</b>
Cllr David Parsons CBE	
<b>Collaboration or bust? Why the NHS should grasp the Total Place agenda</b>	<b>10</b>
Mike Attwood	
<b>Lessons from Total Place 1: the Birmingham experience</b>	<b>16</b>
Alan Lotinga	
<b>Lessons from Total Place 2: the Bournemouth, Dorset and Poole experience</b>	<b>20</b>
Phil Swann	
<b>References</b>	<b>23</b>
<b>Further reading</b>	<b>24</b>

## Introduction

Total Place has been held up as an example of a radical initiative that demonstrates how a whole area approach to public services can achieve better outcomes for local people at a lower cost. It has attracted high-level interest and is seen as a key means of achieving more with less – a critical challenge for policy-makers, managers and practitioners for the foreseeable future. The evaluation of the 13 Total Place pilot programmes was published by HM Treasury earlier this year (HM Treasury 2010a).

But what has Total Place meant for the NHS? To what extent were local NHS organisations involved in Total Place pilots, and what outcomes did they achieve? Do place-based approaches represent just another distracting external initiative, therefore being part of the problem, or could they in fact be part of the solution to productivity and efficiency challenges? How will they feature in the evolving policies and priorities of the coalition government?

This report captures the content of a conference held by The King's Fund on 1 June 2010 to explore these issues. Barely three weeks after the formation of the coalition government, this event was a key opportunity to assess the involvement of the NHS in the Total Place programme, with presentations from three of the pilot projects in which health organisations have been a pivotal partner. It was also an opportunity to consider how the Total Place approach might be applied in the context of the new government's priorities and the imminent squeeze on public spending.

### *Background and history*

Total Place was launched as part of the 2009 Budget as a key recommendation of HM Treasury's Operational Efficiency Programme (HM Treasury 2009). It involves local public services working together to deliver better value services to citizens by focusing on joint working and reducing waste and duplication. Initial evaluation offers promising evidence that a place-based approach to local public services can deliver better outcomes and improved value for money. However, this evidence is relatively undeveloped, and not yet a reliable foundation on which to base future spending decisions.

The NHS has had significant input in the 13 pilots, which involved a total of 34 primary care trusts (PCTs), 63 local authorities, 12 fire authorities and 13 police authorities (HM Treasury 2010a). Feedback from participating PCT chief executives has also been positive (NHS Confederation 2010). Based on the findings of the Treasury evaluation and the contributions of NHS colleagues at The King's Fund conference, we can make four broad claims about what Total Place can offer:

1. It offers a means of reshaping resources based on the needs of people and places rather than through the funding streams of individual organisations, putting citizens at the centre of service redesign. In this sense, Total Place can be seen as an integral element of public service reform, and dovetails with prevailing philosophies of personalisation and choice that enjoy broad political support.
2. It provides a methodology for achieving efficiencies in how public resources are used by eliminating waste and duplication. For example,

it has been estimated that achieving 2 per cent savings in 2013/14 across those elements of public spending that are locally controlled would release more than £1.2 billion in England (HM Treasury 2010b). As the coalition government's deficit-reduction plans start to bite, it seems certain that this and other methods of achieving more with less will gain increasing political and administrative traction.

3. It represents a different template for collaboration between local public service organisations, and the joining up of health and social care services that have thus far eluded previous initiatives based on organisational or financial models, such as care trusts or pooled budgets.
4. It is an opportunity to recast a historically tense and ambiguous relationship between local public service organisations and the centre; it could herald a new relationship with central government based on freedom from central performance and financial controls, freedom and incentives for local collaboration and investment in prevention. These benefits are more relevant to local government than the NHS, where policy levers and governance arrangements are substantially different.

### **The changing policy context**

These claims should be given serious consideration, not only because of the evidence from the pilot programmes but also because of the relevance of the approach to the policies and priorities of the coalition government. Although place-based approaches are not mentioned specifically, the potential benefits of the approach fit with the new government's policies in a number of areas, including its plans for public expenditure for the next four years.

- The coalition government's programme (HM Government 2010) is littered with references to efficiency savings, reducing waste, and better collaboration between different parts of the public sector; the scale of the efficiency challenges facing the NHS and the lack of protection afforded to social care budgets underscores the need for further savings.
- After the publication of the June 2010 emergency budget, the Director of the Institute for Fiscal Studies (IFS) said: 'We are looking at the longest, deepest sustained period of cuts to public services spending at least since World War II' (Chote 2010). While the NHS will continue to receive real-terms increases in funding for the duration of this parliament, cuts of up to 25 per cent have been mooted for other departments (HM Treasury 2010b), and NHS trusts will still need to find efficiency savings of between £15 billion and £20 billion by 2014/15 (Nicholson 2009). How the NHS will respond to this challenge locally is uncertain (Harvey *et al* 2009). Given this forbidding context, if the methodologies used in the Total Place pilot to achieve better use of resources did not exist, they would almost certainly need to be invented.
- There is an overarching commitment in the government's programme to 'a radical redistribution of power away from Westminster and Whitehall to councils, communities and homes across the nation' (HM Government 2010). A thematic shift that focuses on the needs

of people and places rather than organisations could help to embed locally driven solutions.

- Similarly, the government's specific pledge to 'break down barriers between health and social care funding to incentivise preventative action' could have been culled directly from a local Total Place report. Familiar hotspots in the health and social care interface – for example, continuing care, hospital discharge or mental health – are highly amenable to a fresh examination through a geographical rather than organisational lens, as the two presentations from Birmingham, and Bournemouth, Dorset and Poole show.

### *Challenges ahead*

There are inevitably some major areas of uncertainty about what place-based approaches can deliver. First, there are concerns about whether they can deliver the scale of savings required from public services in the relatively short time-frames involved. Contributors at the conference were candid in recognising that it is one thing to calculate the potential for large savings, but quite another to achieve them. The possibilities that Total Place offers could be crushed by the sheer weight of expectation. Local collaboration to achieve more with less could be undermined by the impact of real-terms funding increases for the NHS on other services on which it depends, thereby creating new frictions between the NHS and local partner organisations. The scale of the productivity and efficiency challenge within the NHS will place huge pressure on managers, who may be forced to prioritise fiscal firefighting over collaboration to achieve longer-term benefits.

Second, the proposals in the White Paper, *Equity and Excellence: Liberating the NHS*, herald a period of radical cultural and organisational change (Department of Health 2010). The abolition of PCTs potentially destabilises the organisational ability of the NHS to contribute to place-based solutions; GP consortia are unlikely to be coterminous with local authority boundaries, and if their commissioning budgets are excluded from the total local public service spend, it is difficult to see how a place-based solution could work.

Third, much will depend on the quality of leadership across the NHS and local government to take forward the controversial decisions about reconfiguration, decommissioning and reinvestment that contributors described as the logical next steps of their analysis of existing resources. The engagement of clinicians, especially GPs and public health directors, was seen as vital to success, as was winning the confidence of a wide range of professionals in an alternative service model, based on providing care closer to home. Will the proposed new GP consortia, and the NHS Board, be able to muster the capacity and confidence to drive change on this scale?

Fourth, there is a much wider question about whether Total Place is a process response to what is an essentially structural problem: an unreformed welfare state whose principal organisational and professional silos have remained fundamentally unchanged since 1948. In this sense, Total Place could be regarded as just the latest example of overlaying a set of processes on to a deep-fractured series of separate services, rather than the radical and comprehensive redesign of structures and service delivery that is needed. It could be argued that the principles underlying Total Place should drive a much more far-reaching approach to the achievement of 'radical efficiencies' of public services (Gillinson *et al* 2010).

That is well beyond the scope of the discussions at the conference held by The King's Fund, but it is clear that the relevance of place-based approaches to the current challenges and future needs of our health and social care system commands wide support. The potential for substantial savings, better outcomes and re-energised local partnerships is evident. The challenge now is to demonstrate that these results can be delivered in practice.

## Integrated working: breaking down public service barriers

*Cllr David Parsons CBE, Deputy chairman of the Local Government Association and leader of Leicestershire County Council*

For more information, visit: [www.leicestershiretogether.org/](http://www.leicestershiretogether.org/)

The need to reinvent public services in the context of severe spending cuts injects a new sense of urgency into this debate. If the government is truly looking for a 10–20 per cent reduction in spending, there will need to be an appetite for doing things radically differently, and in most cases, the solution will be local. This does not mean structural change; all the evidence shows that people want services to be joined up to meet their needs, but the way this is done needs to be driven by local leadership and co-ordination, not by a nationally imposed system.

There are too many different organisations providing too many services to meet the same needs, making it difficult for people to understand what services are available locally. Too many public sector organisations are spending money on the same things and in the same places, leading to duplication and waste. Money is often targeted at crisis management rather than on prevention. The majority of money that is being spent is on centralised control, often with little understanding and little ability to target according to local circumstances. For example, for every pound spent on public services in one place, only 5p is under local democratic control.

Total Place, or the place-based approach, focuses on how a whole area approach can deliver better public services at a lower cost. It has meant looking for new ways of co-operation at local level, and between the local level and the centre (Whitehall). Leicestershire is one of 13 Total Place pilots that have taken a fresh look at what money is coming into their area.

Typically, in Leicester and Leicestershire, about £6 billion per year is spent on public services, the greatest amount being from the Department for Work and Pensions (DWP), followed closely by the health service (Leicester and Leicestershire Public Service Board 2010). The programme has explored the obstacles to making funding go further. The complexity of the internal wiring of public service delivery, with the quite bewildering array of funding strands and agencies involved, can get in the way of joining up services based on users' needs. For instance, in Leicestershire, most money spent on drugs and alcohol abuse was ring-fenced for drugs, while most police arrests are for alcohol abuse. That seems to me to be mad; we must not lose sight of the fact that local services are about families and individuals with complex needs who use public services the most.

Many of the complex issues chosen by pilots had health services as a key part of their aims. In Leicestershire, we worked with health partners at every level, from our strategic programme board to the pilot team and various working groups. The Bradford pilot focused on improved outcomes and reducing the cost of hospital discharge of older people with mental health problems. This found that improved discharge planning and providing appropriate community support could reduce the number of discharges direct into residential care by 50 per cent, leading to savings of £1.8 million per year (Bradford District Partnership 2010). Place-based approaches

are as much about changing the relationship between places and national government as about the relationships within one place. Getting sponsorship from key Whitehall officials was an important part of this process.

Joint working between health and social care is not new: over the past few years, we've had care trusts, integrated care organisations and 'Section 75' flexibilities allowing for things such as pooled budgets and shared staffing. More recently, we've had Linkage Plus and Partnerships for Older People Projects (POPPs), two government-funded programmes for joint early intervention and prevention services. There are also a number of local initiatives that are not part of formal programmes – for example, the Isle of Wight, which in 2008 introduced free home care for all people over 80. In the first year, this led to a 41 per cent reduction in residential care and a corresponding 28 per cent increase in those receiving home care. This led to savings of £1.4 million on residential care, £1.2 million of which was reinvested in home support (cited in Audit Commission 2010).

There is no 'one size fits all' for integrated working. It is for local partners to determine how much integration works best and what will be most effective in their area. Closer working should be focused on better services to meet the needs of users as well as efficiency savings, and we also have to remember that addressing the needs of older people goes beyond health and social care; wider needs such as housing, transport, leisure and learning all contribute.

There are, however, still a number of barriers to greater integration.

- *Reallocating NHS savings*: one of the findings from the evaluation of the POPPs is that only 2 out of 29 pilot areas were able to secure the reallocation of savings from the NHS back to social care.
- *Different targets and regulatory frameworks*: NHS and local authority partners still find that centrally imposed priorities make it difficult for them to integrate services.
- *Transparency and accountability*: health and social care partnerships need to have clear local accountability. Some partnership arrangements are complex, without clear accountability back to elected representatives. A place-based approach makes a compelling case for these barriers to be removed and replaced with more local freedom to determine priorities and allocate a common pool of resources to the most effective interventions.

What are the proposals from the government? We're pleased to see the commitment in the coalition agreement to breaking down barriers between health and social care funding, and the aim to help older people stay in their own homes for as long as they can. We also welcome the new commission on long-term care. There is an urgent need to build a national consensus on the way forward, and the Local Government Association (LGA) would like to make a strong contribution to the commission. Long-term care for older people is vital and we must address this together, but we must also guard against new barriers being put in place.

In the Queen's Speech on 25 May 2010, the new government announced proposals for a health bill that will include provision for directly elected individuals on the boards of their local PCTs. It will be important not to put at risk the real gains achieved from partnership working between local authorities and the NHS by introducing split mandates through directly elected individuals on PCT boards.



Cynics might say that this just reinforces silos and actually doesn't encourage local cross-party working. The LGA will be looking at this in more detail and raising our concerns with the government. It has been announced that local government is to get a new power of general competence (HM Government 2010). This is good news; it will provide new powers to councils to do anything likely to benefit the local area and local residents, as long as it is within the framework that the LGA has been arguing for. We hope that this will help us to break down some of the barriers between public services. I understand that it has also been made clear that the new government does support the Total Place principles, with the caveat that we don't call it Total Place.

The LGA group set out a far-reaching but realistic set of proposals in a consultation paper, *Freedom to Lead: Trust to deliver* (LGA 2010). It's been clear for some time that the way we regulate and inspect public services is no longer affordable, so we welcome the announcement that the comprehensive area assessment has been scrapped. A radical new approach to assessing the performance of local public sector organisations is required. We want a single approach to assessment of place which should focus on outcomes delivered collectively by publicly funded bodies, and on the way in which the totality of public sector resources is used at local level. External inspections should be concentrated on areas where performance failure could cause loss or harm – for example, safeguarding children and adults – perhaps with the Audit Commission as gatekeeper.

We think that elected councils should have control over local spending via area 'place-based' budgets and be accountable directly to parliament, if not with a person from Whitehall actually sitting on the public service board. If we can be directly accountable to parliament – and actually I doubt we even need primary legislation for that – I think that is the appropriate way forward in cutting out funding agencies, ring-fenced budgets and the excessive reporting requirements that go with that.

Where next? We need to build on these place-based principles and ideas, and we need to see whole area working integrated and embedded across the public sector. Local government is ready to work with the new coalition government to reduce spending and reform the state. Councils are ready to strike a deal with central government that will see local government take full responsibility for delivering more for less. We must seize the moment and continue to invest energy in a new way of working so that, together, we can improve the lives of people around Britain. It will take dedication and effort, and it won't always be easy. But it is a prize worth investing in, and in the current financial climate, we can't afford not to try. We understand about efficiency; the challenge will be to improve productivity across the public sector. I believe that Total Place or place-based solutions are the way forward and that the case is unanswerable.

### *Key messages*

**The financial crisis is an ideal opportunity to think differently about public spending, but barriers to integration remain. Local government should be trusted to take responsibility for spending in their area via area budgets, with a different framework for local freedoms and accountability. This should be reflected in a new performance management and inspection regime, focusing on high- risk services.**

## Collaboration or bust? Why the NHS should grasp the Total Place agenda

*Mike Attwood, Programme Director, Total Place Coventry, Solihull and Warwickshire*

For more information, visit: [www.localleadership.gov.uk/totalplace/pilot/coventry-solihull-and-warwickshire/](http://www.localleadership.gov.uk/totalplace/pilot/coventry-solihull-and-warwickshire/)

With a background as a PCT chief executive, I am very familiar with hard challenges of turning around financially challenged organisations and the risks of damaging services in order to achieve financial balance. Difficult conversations with council overview and scrutiny committees were dominated by what not to cut, rather than practical alternatives. And as chief executives, we can be too wedded to our organisations. I recall a community learning disability team manager who pointed out to me that while I was expecting him to work as part of an integrated team, local chief executives were still arguing about whether to have shared back-office services. So I welcomed the Total Place programme as an opportunity to have different kinds of conversations and explore different solutions. Total Place is about culture as well as counting, offering new ways of working together and better accountability.

Within Total Place, we start off by counting all the public sector money that's coming into an area. I think what is very different is the different working relationships with Whitehall. I have been working with a number of directors-general who are thinking really hard, asking 'How do we get more joined-up strategy and more joined-up policy across government?' and 'How do we start understanding the large amount of national delivery spend that goes through local areas from central budgets – for example, Jobcentre Plus, benefits, and so on? This work is led by the Leadership Centre on behalf of the LGA group, who have provided really good support and challenge to us as pilots.

The scale of the challenge is beyond any single organisation. What we are trying to do is to take partnerships from marginal to mainstream, from maybe 1 or 2 per cent of our turnovers to mainstream joint ventures.

### *Why should the NHS be involved in Total Place?*

The NHS is comparatively highly performing (Commonwealth Fund 2007) but productivity, although beginning to rise, actually fell quite badly over the 10 years up to 2007. When PCT allocations are mapped onto spend on Payment by Results (PbR) in acute hospitals, they are very similar, so a lot of this money has gone straight over into acute care.

**NHS Context 1**

- Comparatively highly performing already (Commonwealth Fund 2007)
- Productivity fell by 4.3 per cent between 1997 and 2007 (Office for National Statistics 2009)
- 1.1 per cent increase per year needed for demographic growth alone (Harvey et al 2009)
- Efficiency needed by 2014 is 15–20 per cent (Nicholson 2009)
- The best-performing companies manage annual productivity increases of 2 per cent per year (IFS); we need 4 per cent (The King’s Fund)
- Direct relationship between PCT growth in allocations and PbR spend

From a patient or client perspective, a 3 per cent rise year on year for type 1 diabetes in children means some fundamentally different approaches with schools, nurses and other parts of the system, as do increases in obesity among men.

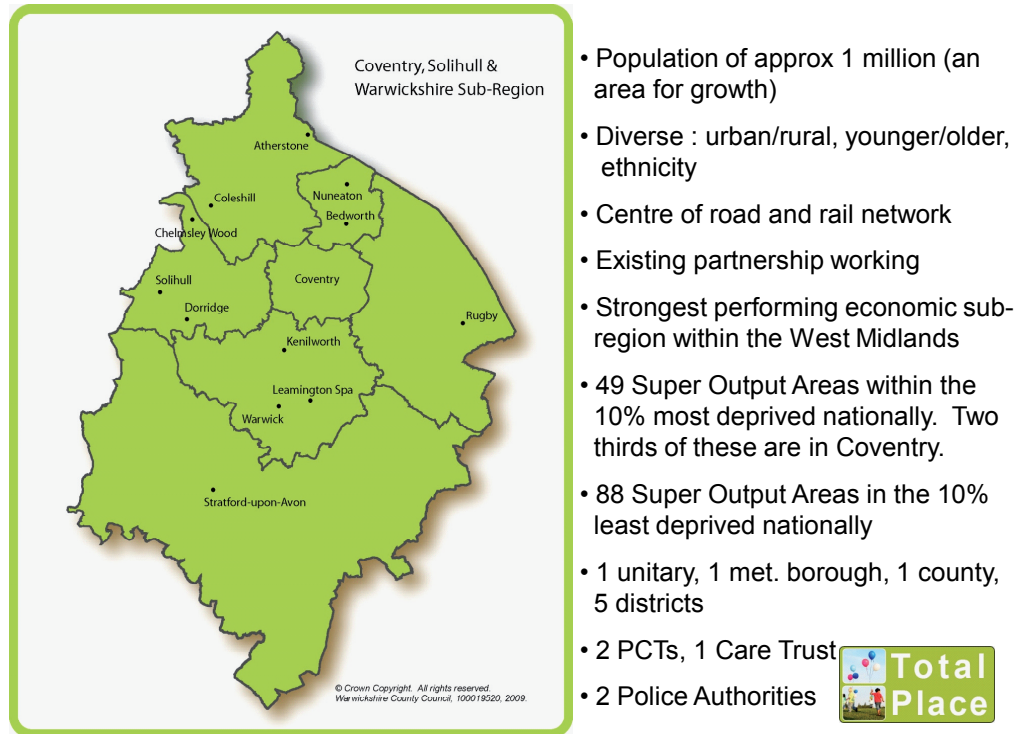
Forty per cent of cancer deaths are still taking place in hospital, so a Total Place approach to palliative and end-of-life care is really important, because the biggest challenge with end-of-life care is helping the public to take a completely different approach to where people die. That is not something the NHS can do by itself.

Then, finally, certainly in urban deprived areas, there is growing evidence of correlation between GP practice size, unit cost and quality. Most members of the public understand the GP and they understand the acute hospital. Asking them to put all their faith into an intermediate care team or a rapid response service is difficult, as we haven’t yet got alternative health services that feel solid and owned by the public. With democratic accountability, we may have a way of doing that – hearts and minds are very important. So the conversations we are having are about shaping hospitals differently and about how GP services are going to look.

**NH S context 2**

- Type 1 diabetes in children is rising by 3 per cent per year (NHS Confederation)
- Male obesity has risen from 13.2 per cent to 23.6 per cent between 1993 and 2007 (NHS Confederation)
- 52 per cent of 2005/6 growth was hardwired into increased pay (NHS Confederation)
- More than 40 per cent of cancer deaths still take place in hospital (West Midlands)
- 13 per cent of bed days are excess bed days (West Midlands) – equating to 2 per cent of Coventry PCT turnover
- Growing evidence of correlation between GP practice size, unit cost and quality

**Figure 1 Coventry, Solihull and Warwickshire sub-region: defining the 'place'**



Coventry, Solihull and Warwickshire has a population of 1 million, so it is big enough to run specialised health services and complex council provision like strategic waste services, and to bring three tourism services together. There are three PCTs, three large local authorities and five districts – so although it’s complex, it is manageable.

When we did our big count, the first thing we realised is that about 50 per cent of local spend is by national agencies. About £1 in every £6 goes to children’s services, but critically, 70 per cent of the council spend goes through the Direct Schools Grant. This raises tricky issues for the government to think about – for example, giving more powers and money to schools and GPs is right, but if the council cannot then look at the Direct Schools Grant in terms of productivity and efficiency, this creates difficulties. I would argue that devolution of power and budgets should be accompanied by these services having to be accountable for value for money and the development of mature networks for this to happen.

We need to make sense of competing national drivers; although we want to work in a much more local way, there are tensions around how we make sense of a big expansion in GP commissioning and more power for schools. At the moment, foundation trusts don’t really have the incentive to work in the whole system way that perhaps we need them to.

Late intervention with a young person not in employment, education or training costs four times that of a successful early support package. But unless you have a local concordat, police and probation save that money and health and education spend it. You have to have a place-based budget to be able to handle those kinds of shifts, because local investment streams need to change. The other issue for us is that capacity has to come out as well as shift. I think most of us in the NHS would say that we are going to have to

take some buildings and probably some hospitals out of the system, and that is going to mean frank conversations with local and national politicians.

### *So what are we doing?*

We're working initially with children and young people and we're doing three programmes that are about services, taking manageable chunks of work that can be rolled out across the whole system.

- We're looking at how we can integrate child health and children's centres better. If we get single assessment working really well, the health service can stop providing some health centres and clinics that it doesn't need and we can probably stop spending 20 per cent on agency social work through the local authority, so you can connect small-scale redesign to quite large-scale savings.
- e're working on one, single bullying strategy to be implemented across three children's trusts so we can reinvest the savings back into better training, better publicity and better engagement. If that works, maybe we need one children's trust or one children's trust network so we can start collaborating in other ways strategically. The projects for young people not in employment, education or training work very similarly; how do you get a group of relatively autonomous schools and colleges to offer a more consistent but flexible offering for kids who are dropping out of the system, and how do you pool those savings when the police will save and the health service will spend? So these are little learning lab-type projects, which are very scaleable.
- We're doing a programme with the three school improvement services from the three local authorities to work towards one school improvement service. Within that, you might need some CAMHs (child and adolescent mental health services) advice and you might need some low-level health advice, given the connection between poor health care, poor health outcomes and poor educational attainment. So that is another approach to a shared service.
- We're working with central government; the last government announced a reduction in children's field forces, (the children's equivalent of the national support team) from 36 to 29. If you are central government, you're probably not going to give improvement resources out to 150-odd PCTs, but actually you might to a sub-regional partnership that has shown itself mature enough to be self-improving. We think you can be drawing a new line between inspection and regulation.
- We're working on shared services. We've started with school recruitment services but we're about to try and move towards an HR service that's joined up across the whole system.
- Finally, we're trying to build capacity, so we are shaping up a sub-regional learning and leadership academy, and we're hoping to move towards one observatory.

So our overall approach is this new concordat with central government, starting with children's services, but making sure that we present ourselves as an accountable and mature sub-region. We have taken small projects that we think are scaleable and we are trying to be realistic about the fact that

we are going to have to do traditional value for money work as well as this transformational stuff. Total Place is not a silver bullet. We are just about to do some modelling with the strategic health authority (SHA) to make sure that the QIPP (quality, innovation, productivity and prevention) plans for Coventry, Solihull and Warwickshire do align, and we haven't got perverse incentives running across the system.

The Design Council is helping us on the children's centre work, using proper design principles and working out how to use what they call 'customer insight' in design work, which can be very powerful. Some of these user stories are almost what I would call 'guilty knowledge' – once you know it, you have to do something about it. Through this leadership academy, we are trying to set up a lean practitioner network, because we are finding that middle managers are better equipped than senior managers these days in terms of lean technology and efficiency reviews. However, we do not have enough critical mass within our managerial workforce in terms of how you engage with the public, how you do a lean review, and some of the science of actually doing service redesign. We're working with Warwick Business School to develop this capacity quickly.

### *What is the concordat?*

The concordat is a deal between central government and us as a sub-region. It's about trusting local systems to respond and deliver, and it represents a very different approach to national strategy.

Taking children as an example, Every Child Matters has been a good overarching way of developing children's services, but it builds on what the Department of Health does with the PCT separately – so the single system tends to get built on to existing individual systems rather than being created as a whole system from scratch. So I would argue that the Department for Education should be the lead for children's strategy and we need stronger regional ministers so that the dialogue between central government and the local system is strengthened.

Aligned target setting and performance regimes are very important, and less ring-fencing would bring new financial rules, involving place-based financial allocations and what we would describe as a three- to five-year programme of 'Better for less' – a system-wide plan that will replace targets with 10 outcomes. That should be tied to a Total Place or a place-based budget, and within that, we should build local partners of national delivery organisations. For example, we think there is a case for a devolved approach to Jobcentre Plus budgets.

The concordat also needs to include a fair degree of political nerve because the 'Better for less' plan will involve some decommissioning and will include some system change. It can't be a three-month consultation; it has to be done in a very different way, and we think that that needs to be piloted, and would propose most probably doing it with children's services first.

### *What are we learning?*

We are moving from an intellectual to an emotional understanding that we are co-dependent as organisations, and that political leaders and chairs have to be in this together. Partnership is gradually becoming core rather

than extra. The national–local element is what is really different about this. I think there is an issue about the incentives that we have as chief executives and senior managers – the duty of partnership needs to be strengthened significantly. For the NHS, I think it is clear that some savings are going to have to be invested in other parts of the system (for example, into social care), and I think local authority leaders might feel more brave about having conversations about whether a hospital is viable and whether to build strong community health and social care services.

The Department of Health QIPP programme nationally still feels parallel to much of this work. In the short term, however transformational we want to be, we have got to risk assess each others' savings plans in the here and now to make sure we don't damage each other. There are some quicker wins: we will get out of some buildings quite quickly, we will get some big agency and locum staff budgets down quite quickly, and we are taking our two next big steps. We are just about to do a big optimal care pilot around older people, and the local authorities have just agreed to pool all their sub-regional working. Actions are beginning to speak louder than words.

### *Key messages*

**The changed financial context for the NHS gives a new impetus to finding new ways of working. Total Place offers fresh opportunities to have different conversations with partners, develop better accountabilities across partnerships and a different relationship with central government. Design principles can be applied to small projects, which can then be scaled up and rolled out across other organisations. Concordats can be a powerful tool for implementing Total Place solutions. Local organisations need to recognise their co-dependency.**

## Lessons from Total Place 1: the Birmingham experience

*Alan Lotinga, Director, Birmingham Health and Wellbeing Partnership*

For more information, visit: [www.bebirmingham.org.uk/documents/TP\\_Birmingham\\_Final\\_Report\\_version\\_2.pdf](http://www.bebirmingham.org.uk/documents/TP_Birmingham_Final_Report_version_2.pdf)

I am Director of the Health and Wellbeing Partnership, which is a partnership between Birmingham City Council and the city's three PCTs. The whole of the city council is involved, but particularly adults and communities, social care, children's services, housing, and constituency services. I am a city council employee but I am co-funded by those partners.

As one of the 13 Total Place pilot programmes, we structured our work around 4 programmes and 15 work streams. The four programmes are:

- needs and engagement, including the joint strategic needs assessment, community engagement
- health inequalities, which range from obesity, life expectancy, infant mortality, improving health and increased employment, to tobacco control/smoking cessation
- joint commissioning, where we have established a Section 75 agreement across mental health and learning disability which I'm told is the biggest in Europe, and work streams around delayed transfers of care and complex care. Knowledge management is crucially important; we have got to make progress on joint information, joint intelligence, joint data and the use of that. We want to pick up the baton around things like intermediate care enablement
- personalisation, which covers areas such as individual budgets, end-of-life care, carers and so forth.

### *Key health challenges in Birmingham*

In terms of health inequalities, there are some particular things that apply to Birmingham. First, it's quite a young population, and the projections are that it will stay fairly young. We do have particular challenges with black and minority ethnic older populations in the coming years, but generally, we have poorer people who spend more time grappling with deprivation and ill health, and they don't tend to live as long. Second, child poverty is a huge challenge in and across Birmingham in terms of its scale and its concentration. One crucial example is infant mortality rates. For a while now, Birmingham's infant mortality rate, in terms of youngsters surviving the first 12 months of their life, has been at least twice the national average, which is unforgivable. This is a health improvement, health inequalities priority, and must not be dropped because the system changes around you.

### *Total Place themes*

In terms of our Total Place pilot, we had six themes:

- gangs
- early intervention



- learning disability
- mental health
- drugs and alcohol
- community demonstrator (East Birmingham).

If you visit [www.birmingham.org.uk](http://www.birmingham.org.uk) you will see our February 2010 report to the Treasury on the Total Place pilot, and you'll see a lot more detail on each of these themes and generally, in terms of the Total Place experience.

In terms of early intervention, we established that the city council could expect to generate savings of about £400 million by investing another £40 million over the 15 years, but only 25 per cent of that would accrue back to the local authority.

We are talking about large-scale pooled budgets and joint commissioning in learning disability and mental health, but also trying to take advantage of the personalisation and co-production agenda, reducing the average cost of care packages for people with learning disabilities over the next 10 years. We currently spend about £54 million on 260 people in Birmingham with learning disabilities, which is, on average, £200,000 per person. That's not to say we shouldn't be spending a lot of money on those 260 people, but you can see why there is an emphasis on high-cost packages.

In drugs and alcohol, we are redesigning services to dramatically reduce the number of people with drug abuse returning into the system, and also people with severe alcohol problems attending hospital. The community demonstrator pilot is particularly interesting because it has heavy involvement from the NHS in a particular part of east Birmingham, and among other things there, we are trying to concentrate on a more productive joint use of joint assets, generating community hubs and aligning our respective modernisation and transformation agendas.

The Total Community demonstrator project in east Birmingham shows how Total Place can work in a particular geographic location by focusing on a relatively deprived area. This offers a geographical prism through which we'll see a range of these things being tested and aligned and our respective modernisation programmes really put to good use rather than going their own separate way.

**Key facts relating to the Total Place themes in Birmingham**

We have about 18 funding streams supporting offender management; there are about 100 public buildings in one constituency alone and there are 10 parliamentary constituencies across the city. Each high-contact family primarily dealt with by children's services and a range of partners, including the NHS, currently costs the public purse about £250,000 each year.

We have 24 dependent drinkers, costing £2 million per year. We have two dynastic crime families that have cost the criminal justice system alone nearly £40 million over the past 20 years.

A 1 per cent fall in smoking prevalence could save about £17 million per year for the local economy in terms of sickness absence, for example. This is across the private and public sectors.

Some 53,000 people across Birmingham and Solihull claim what used to be called incapacity benefit; we know from surveys and conversations that at least 20 per cent of those people are eager to work, so the NHS is key in terms of 'fit for work' notes, and is also a big employer.

We have some 41,000 falls each year, more than half of which result in avoidable health and care costs and long-term disability.

*How to build on our current work*

There are four areas here that we need to do more work on to establish this as the way things are done in Birmingham.

First, we need collective leadership and new governance. We need to rationalise and properly resource capacity so that we can deliver on the specifics rather than just continue to talk about them. With work around depression and early onset dementia, guns and gangs, and falls prevention, the case is there and we need to get on and roll it out. There have to be some really brave decisions around capacity – we can't spend extra money, so we have got to stop doing some things.

Second, we need full scrutiny and oversight, but we already have far too much bureaucracy around scrutiny and reporting. So one of our key priorities over the next weeks and months is to get more trust and simplicity in the system. We need better communications and marketing, both internal and external. A budget for Birmingham is a key aspiration. This involves risks, and prompts fears of taking over the NHS budget. But the budget needs to be increasingly signed up to outcomes, not organisations. It has got to get the right time-frame balance between short-term investments and disinvestments, and long-term gain. This has to be evidence based, which is why knowledge management is a top priority for the Health and Wellbeing Partnership. Risk sharing has got to be made explicit; there is no excuse, the devil is in the detail.

Third, we need to make the most of research and intelligence. There is some great work that has been done elsewhere in the country on Total Place and other initiatives in terms of engine rooms for change, generating proven data that people can trust and use.

Fourth, we often talk about self-sufficiency, but if we are not connecting with the citizens in some practical and effective ways, we will miss the obvious,

and just continue to do things 'top down', so there is a real challenge. We need to work with key allies, crucially GPs, so that we move from people saying simply 'I work in my organisation' to 'I work for Birmingham'.

To conclude, enthusiasm and expectations around Total Place have built up and we really need to deliver now. We have laid some fantastic foundations. Increasingly, colleagues in the NHS are getting up to speed, alongside everything else they are having to deal with. We are clear about what we want to do next in terms of the broad areas I have outlined. We now need to get on and do it and earn some trust. In areas like falls prevention, we need to actually get some things in place, show the savings, and show the better outcomes (even if it is within a single agency situation), so we can build on that trust and grow it across agencies. It will be an interesting year.

### *Key messages*

**Birmingham's city-wide approach aspires to achieve a 'budget for Birmingham'. Together, the council, PCTs and other partners have demonstrated the potential benefits of better outcomes and reduced costs; realising these benefits will require collective leadership, new governance and a focus on delivery.**

## Lessons from Total Place 2: the Bournemouth, Dorset and Poole experience

*Phil Swann, Project Director, Total Place Bournemouth, Dorset and Poole, and Programme Director, Shared Intelligence*

For more information, visit: [www.dorsetforyou.com](http://www.dorsetforyou.com)

Betty is 86, and lives in rural North Dorset on her own. She often gets nervous at night, and got in the habit of dialling 999; an ambulance would come and take her to hospital. This was costing the NHS around £19,000 a year. Her GP spotted this pattern and arranged for a local voluntary group to phone Betty at least once a day; Betty could also ring them instead of 999 if she felt nervous. We discovered there were hundreds of women like Betty across Dorset, and many unnecessary hospital admissions. The question we addressed through our Total Place pilot programme was: How can we get improved outcomes at less cost through greater collaboration between agencies, a different sort of engagement between the state and local citizens and communities, and a genuine focus on place?

### *Focusing on support for older people*

The focus of Total Place in Bournemouth, Dorset and Poole has been on support for older people; it has involved one county council, two unitary councils, six district councils, two PCTs, the police authority and the fire authority. Organisations have carried much historical baggage and partnerships have not been easy.

The area had a high and rising level of emergency admissions to hospital, particularly among older people. There was historically low local authority spend on social care for older people, and some stark differences between the three main authorities, with high levels of residential care in Bournemouth and very low levels of residential care in Dorset and Poole. There had been a recent significant increase in investment in preventative activities, such as the example above.

Evaluations showed that prevention was working, but expenditure on older people in hospital and emergency admissions continued to shoot up. This suggested that investment in preventative activity was having no impact on the health and social care system and was benefiting only a few individuals. This was the context for our work on Total Place.

### *Achieving better outcomes*

Our objective was to inverse the triangle of care – to shift the focus of investment towards activity in or near people's homes rather than in hospital. We knew that at least 30 per cent of older people admitted to hospital in an unplanned way were avoidably admitted and need not be there; the NHS was able to supply some very rich data on this. We calculated that if we could divert 15 per cent of those avoidably admitted and had their needs treated either in their homes or closer to home, the annual saving would be around £18 million.

The cost of alternative provision for those people, and beginning to ramp up

a genuinely preventative approach, would be about £6.6 million a year; we also identified 'social capital' – genuine low-level community-based activity – as an important element of the preventative activity. An additional £1 million investment in that low-level community activity across Bournemouth, Dorset and Poole would transform the level of provision.

So is it possible to get improved outcomes for older people in Bournemouth, Dorset and Poole at a lower cost? The maths – £18 million savings minus £6.6 million on preventive services and £1 million on social capital – are self-evident. And it was clear from survey work that older people showed a strong preference to receive care closer to home rather than in hospital.

### *Key challenges ahead*

There are some significant challenges arising from our work on Total Place. The first is the whole question of political leadership at national and local levels. Although most of my career has been spent outside of the NHS, some of it in transport, I quickly concluded that acute hospitals are a bit like the M25. For as long as they're there, they will be full, so there has to be a grown-up debate, nationally and locally, about the need to significantly reconfigure hospital provision in order to realise the savings that we've identified. I remain unconvinced that there is the political appetite for that, either nationally or locally. Creating the conditions in which a grown-up political debate can happen is the key to achieving improved outcomes at lower cost in relation to services for older people. This applies as much locally as nationally.

Then there are a number of very important organisational and cultural issues for local organisations. The most obvious arises from data which show that most avoidable admissions to hospital happen after 6pm on weekdays or at weekends. Ensuring that alternative provision is available every day of the week, 24 hours a day, is an important shift that is necessary if we are to achieve improved outcomes at lower cost.

Even more challenging is the whole question of building trust and confidence in alternative provision throughout the system, from paramedics through to GPs, commissioners, and clinicians in A&E departments. Part of this challenge will involve de-medicalising some of the needs and problems that are presented to the system. Betty did not have a health problem as such – she needed a phone call, not an ambulance or a hospital.

Finally, there are some key governance and financial management issues. Achieving better outcomes at lower cost, in crude terms, involves local government spending a little more in order to help the health service save a lot more. But the challenge of getting a sensible debate about achieving this locally was kind of soured by a view among health colleagues that local government was underspending anyway. History, and perceptions of history, were undermining the capacity for an open dialogue about moving resources from one budget stream to another.

A further consideration arising from our work was the necessity of tackling difficult service reconfigurations at sub-regional level because of hospital catchment areas. All three councils and their NHS partners had to be engaged, and this complicates the effects of history and fears of takeover in either direction. There needs to be a strong and genuine desire to overcome these obstacles in order to achieve better outcomes for local people.

### *Lessons learned*

There are some clear lessons from the Bournemouth, Dorset and Poole experience for those who want to emulate this approach in their own area.

- Buy-in is everything, not only across organisations but also within them – heads of service and directors of service as well as chief executives and leaders.
- Keep it clear and as simple as possible, focusing on the outcomes you want to achieve.
- Maintain momentum: the very challenging timetable imposed by HM Treasury did actually help to avoid slippage.
- Maintain ambition: one of the most effective things we did was to have an external challenge day, where we invited representatives from other authorities, from Whitehall and Westminster, and from organisations like The King's Fund, to come and constructively challenge what we were doing. The level of ambition locally shot up after that day.

Those of you with children will recognise the importance of play as a way of learning. This can apply to organisations too. Total Place – planned and implemented in a focused way – provides an opportunity for organisational play, to extend the ambitions of what you can achieve locally.

### *Key messages*

A place-based approach has identified substantial savings from reduced hospital admissions and care closer to home; the reconfiguration of hospital services on which this depends requires mature political debate and an open dialogue between partners about moving budget streams. Winning the trust of professionals in alternative services is vital.

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## Further reading

Jameson, Heather

### **What next for Total Place?**

*Municipal Journal 2010*, pp 16–17 (3 June 2010)

Almost a month into the new government, questions arise over the future of Total Place. Does this mean this is the end of the policy? *The MJ* and *Capita* last week gathered together some of the top experts on Total Place – including former Communities and Local Government Secretary, John Denham – to ask what the future holds.

Centre for Public Scrutiny (CPS)

### **Accountability works!**

London: CPS, 2010

This report discusses the future of accountability in the public sector and highlights the need for robust local accountability arrangements to go alongside a reduction in central regulation and inspection. *Accountability works!* identifies the many different forms of accountability and introduces the concept of a 'web of accountability' which supports a more collaborative approach to delivering local services and is a vital counterpoint to new service delivery models such as Total Place.

[www.cfps.org.uk/uploads.php?file=awwebcopyfinalfull.pdf](http://www.cfps.org.uk/uploads.php?file=awwebcopyfinalfull.pdf)

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Burton, Michael

### **Plotting the next steps for Total Place**

*Municipal Journal 2010*; pp 14–15 (1 April 2010)

The day after last week's budget, the Treasury and Department for Communities and Local Government published their joint report into the 13 Total Place pilot findings ['Total Place: a whole area approach to public services.'] with recommendations about how to take the programme forward. Michael Burton reports.

Leslie, Chris and Keohane, Nigel

### **Seeds of change**

*Public Finance 2010*; pp 24–5 (19 March 2010)

Evidence from the Total Place pilots shows that the government's big new idea for funding local services will need nurturing in Whitehall. Chris Leslie and Nigel Keohane explain why it means change from the ground up.

Treasury and Department for Communities and Local Government

### **Total Place: A whole area approach to public services**

London: HM Treasury, 2010

Total Place sets a new direction for local public services, based on extensive work over the last year by central government, local authorities and their partners. The measures set out in this document build on the complementary reforms set out in *Putting the Frontline First: Smarter government* and the government's work to co-ordinate and rationalise burdens on frontline public services. Total Place is demonstrating the greater value to be gained for citizens and taxpayers from public authorities putting the citizen at the heart of service design and working together to improve outcomes and eliminate waste and duplication. This document outlines the way forward for places, led by local authorities with their unique local democratic mandate, but requiring the active engagement of government and all local service delivery bodies. It presents a series of commitments that will give greater freedom and flexibility to support a new relationship between government and places.

[www.hm-treasury.gov.uk/d/total\\_place\\_report.pdf](http://www.hm-treasury.gov.uk/d/total_place_report.pdf)



Williams, David

**Ministers mull over early results from Total Place**

*Public Finance 2010*; pp 16–17 (19 February 2010)

The first reports from 13 [Total Place] pilot projects provide a wealth of data. One thing is clear: public services focus too much on symptoms and too little on causes. David Williams investigates.

Mooney, Helen

**How partnerships can maximise resources**

*Health Service Journal 2010*; 120 (6194): pp 24–5 (18 February 2010)

In the final part in our series on Total Place, Helen Mooney looks at how Birmingham's pilot is focused on cutting through organisational boundaries and slashing waste while delivering better services.

Mooney, Helen

**Why working together boosts independence**

*Health Service Journal 2010*; 120 (6193): pp 22–3 (11 February 2010)

Offender management in Luton and Central Bedfordshire is cumbersome and costly. In the second article in our series on Total Place, Helen Mooney looks at how the NHS, local government and agencies are using the scheme to tackle this.

Taylor, Stephen and Swann, Phil

**The pilots are only the end of the beginning**

*Municipal Journal 2010*; pp 22–3 (4 February 2010)

The submission of Total Place pilots' final reports to ministers this month [February 2010] marks not the end of the process but just the end of the beginning, say Stephen Taylor and Phil Swann.

Sharman, Nick

**The opportunity of a lifetime**

*Municipal Journal 2010*; p 23 (28 January 2010)

The combination of two new powerful concepts, Total Place and strategic commissioning, could drive real devolution to local level, says Nick Sharman.

Tizard, John

**Whitehall has to trust localities to make decisions**

*Public Finance 2010*; pp 24–5 (5 February 2010)

Total Place could help solve the problem of drastic funding cuts for local services. But it's going to be a steep learning curve for both Whitehall and town halls, says John Tizard.

Mooney, Helen

**Why partnerships make total sense for savings**

*Health Service Journal 2010*; 120 (6192): pp 24–5 (4 February 2010)

In the first of three articles on Total Place [a pilot programme looking at how public money is spent in a local area and how it can be used more efficiently to improve local services], Helen Mooney looks at how Croydon's PCT and council are using the scheme to focus on improving child health.

Smulian, Mark

**Pooling power**

*Health Service Journal 2009*; (6187): pp 30–31 (17 December 2009)

One solution to the cost-cutting era looming over the NHS could be the Total Place programme, in which local public sector budgets are co-ordinated for greatest impact.

Watson, Phil

**Why the public sector must learn from its past**

*Municipal Journal 2009*; p 17 (20 August 2009)

The author argues that cross-sector working is the best approach to achieve better outcomes and efficiency savings in the public sector. The Total Place approach, which maps public expenditure such as health within a borough, is a useful tool providing intelligence to inform joint working. [www.localgov.co.uk/index.cfm?method=news.detail&ID=81477](http://www.localgov.co.uk/index.cfm?method=news.detail&ID=81477)

Jameson, Heather

**Why a total future must not be a total farce**

*Municipal Journal 2009*; 18-19 (20 August 2009)

As the Total Place agenda gathers pace, *The MJ* held a roundtable event with local authority chief executives and some of their partners to understand more about the barriers and benefits of joining up, and what will happen if they don't. Heather Jameson reports.

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