I know there is a lot of work going on around creating integrated community teams, but Jo asked me along to talk a little bit about what is going on in other parts of the country, in case it is helpful.

In preparing for this session I was reminded of the story that at the end of days there will be four life forms. Two will be cockroaches; two will be trying to integrate health and social care. It's funny but it does point to how long many of us have been working to change the approach to the design and management of work in the system. All of us have had experience of the little madnesses that prevent us from doing the right thing for people, or that prevent people from getting the help they really need, or prevent people from simply helping themselves and building on their strengths despite our best intentions.

What I would say is that where there seems to have been the most success, with success being defined conventionally as reduced demand on the system, whether that is A&E, practices, adult social care or somewhere else, is where teams have moved away from trying to:

- Do service improvement programmes
- Implement system change initiatives or
- Deliver efficiency drives

and instead have replaced them with understanding people, their context and what matters to them. Some call it relational working, others holistic care, others person centred care. Whatever it's called, the fundamental principles are that these teams work:

- Relationally
- Collaboratively and
- Purposefully

Crucially, they do this with a citizen and community focus, rehumanising what has become an industrialised and standardised, one size fits few, approach to care that sometimes seems one step removed from the reality of people's lives.

And I think we are all aware of the real-life consequences of not paying attention to people as people and the things that will make a difference in their life. That can range from

- Repeated referrals – not me, not here, you're not ready or
- You get what I have, not what you need
- To actual harm

All of which add to cost, duplication, errors and all the issues we are aware of from our own experiences or those of friends and family.

As a result, they are designing responses that are bespoke by default because they are better understanding what a good life looks like for people and doing those things.

One of the key methods they have used is to understand demand. But not in the conventional sense of measuring activity volumes, or the number of transactions someone has with the system.

Instead, they are distinguishing between 'value' demand – the reason someone puts their hand up for help – and 'failure' demand – the failure to do something or doing something right for someone.

By giving people a good listening to, they are building trust and starting to become aware of signals rather than triggers; the difference between the trapped rather than the tangled. Whereas, in the past, getting behind on Council tax, rent arrears and stopping paying for school lunches would be a

trigger to chase debt, they are now recognising them as signals that people need help and are getting alongside people to find ways to do that

As a result, they are learning that access to services doesn't always mean success. Getting in doesn't always mean getting help – at least not the help they need. They are learning that there are large amounts of capacity used to deal with failure demand and all the frustrations that creates.

Rather than trying to understand user needs from a focus group, or making assumptions about what people need; they are being alert to people's desired paths, understanding the individual users actual purpose more directly by paying attention to what matters to them.

I'll will leave you with a few final thoughts. Firstly, as important as population health concepts might be, populations don't experience outcomes, people do.

Secondly, as W Edwards Deming, the person who is said to be instrumental in restoring manufacturing capacity and quality to Japan after the second world war, said, *'Most people imagine that the present style of management has always existed, and is a fixture. Actually, it is a modern invention: a prison created by the way in which people interact'*

In other words we invented this system we can reinvent it.

Finally, we talk about integrating care, but we never ask why it is disintegrated. That can lead us to think that the solutions lie in more of the things we are accustomed to, rather than taking the step to make the differences that really make the difference.

QA