One Ilfracombe
Piecing together the public sector puzzle using a person-centred, local system approach
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Abstract

Purpose – The purpose of this paper is to report the findings of a horizontal integration programme in the South West of England. The programme was unusual insofar as it included the full range of public services being provided in a single town. It was a place-based system framed by the concept that a person’s wellbeing includes their health, economic status and living environment and that they are inextricably linked. As well as aiming for broader system integration, the programme utilised a person-centred approach using service-user perceptions to influence design. It was implemented through a local governance structure using a set of collaborative principles.

Design/methodology/approach – The paper presents personal reflections of the programme manager about the efficacy of the model, its sustainability and the problems encountered. It sets out the principles defining the model and the extent to which the principles were followed in practice.

Findings – Creating a holistic public service based on integration to tackle deep seated problems within a population requires reducing complexity at the interface between citizens and services. A local system model that includes all public services allows for collective responsibility for meeting the service needs of the population augmenting the connections and bridging the gaps between services. There was a recognition amongst participants that service redesign does not require wholesale organisational restructuring but does require creating shared aims and objectives and the participation of leaders with the ability to implement change within their services. A user-led, bottom-up approach provides deeper understanding and traction on the ground but should be combined with top-down strategic support to provide structural sustainability and the ability to scale out.

Originality/value – The paper demonstrates that horizontal service integration based on the concept of wellbeing is possible but faces significant challenges. The benefits and complexities of inter-agency collaboration multiply when enhancing the outcome focus from improving population health to general wellbeing. New theories of implementation and transformation are needed that relate to this important emerging service theme.

Keywords Partnership working, Local government, Multi-disciplinary teamwork, Whole systems, Community empowerment, Public participation, Place

Paper type Viewpoint

Background

Public service reform emphasising coordination has become the policy direction of a number of government departments over recent years. These have been driven by the understanding that citizens want their public services to be joined up, that public services would achieve their aims more effectively if they were, and that the combined public purse can no longer afford the inefficiency of working apart.

There are few public sector organisations that have not accepted the need for service integration to improve the effectiveness and increase the efficiency of their work. This recognition rightly rests on the assumption that services delivered by one organisation inevitably impact upon the demand for the services of another and that a holistic approach will

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reduce the transactional costs of wasted time, duplicated resources and missed opportunities (Snape and Taylor, 2003; Ranada and Hudson, 2003). Yet despite a mandate for change, organisations struggle to develop a holistic approach to service integration for local populations that goes beyond health and social care collaboration (Wyatt, 2002).

It is clearly difficult for local commissioners and providers to attempt to join up services which have evolved independently within separate government departments and national bodies (Davies, 2009; Williams et al., 2010). Differing funding mechanisms, geographical boundaries, governance structures, regulations and organisational cultures make the challenge particularly taxing. Moreover, despite numerous policy attempts to develop partnership approaches and service integration, holistic multi-agency integration across the care continuum remains unchartered territory and there is very little communal cross-sector guidance available to support the process (Cameron et al., 2012; Cohen et al., 2015). Without adequate support to address the real or perceived risks, organisations revert to traditional and established methods of tackling entrenched problems and reducing costs.

Conventional practice has the superficial advantage that processes, costs, and risks are within each organisation’s own control and do not require transformative efforts based on cross-agency coordination. Holistic service integration, on the other hand, is likely to favour a preventative approach where immediate cashable savings are not a motivator (Mayhew, 2009; Dickinson et al., 2013).

In the absence of established guidance, many areas in England are forging their own paths, tackling the barriers that arise on the way and taking a variety of approaches with varying degrees of success. The paper describes one such approach where the system included the full range of public sector services. A set of principles were developed and a comprehensive engagement method was established that informed all plans. The paper provides insights into a possible way forward as well as barriers to successful implementation.

**Ilfracombe – local context and history of collaboration**

Ilfracombe is a tourist town on the North Devon coast with a population of around 12,000. Naturally placed to offer a healthy lifestyle, its coastline has been designated as an area of outstanding natural beauty, the air quality is good and outdoor activities are freely available making use of the coastal paths, off-road cycle trail, beaches and parks. Ilfracombe has a strong and vibrant community spirit with over 100 community groups with active volunteers. Yet despite such favourable conditions, there are factors hindering the ability of everyone in the community to adopt a healthy lifestyle resulting in stark health inequalities.

Life expectancy in Ilfracombe’s central ward is 74.6 years – the lowest in Devon and 15 years lower than the village of Newton Poppleford in East Devon. In comparison to the rest of Devon, Ilfracombe has the highest rate of working age sickness which, at 10 per cent, is more than double the Devon rate with the majority of incidence being related to mental health. Emergency hospital admissions, alcohol-related admissions and urgent care attendances are significantly higher, as are death rates from cardiovascular diseases and cancers. Despite publicly funded investment in health improvement programmes Ilfracombe has remained firmly entrenched at the bottom of the health league table.

It is clear that the wider social and economic determinants contributing to residents’ poor health are mostly outside the conventional remit of the NHS. These are contributing to deprivation, particularly concentrated in the town’s central ward. The strong association between poverty and ill health is well understood with health risk factors clustered amongst those population groups that are under-resourced and disadvantaged. In total, 19.5 per cent of the population in the Ilfracombe electoral ward are dependent on benefits or tax credit and 17.5 per cent of the same population are involuntarily excluded from the labour market.
Fuel poverty is significantly higher and there is a significantly lower attainment of five or more GCSEs at A* to C.

Low wages, seasonal employment, poor transport links and poor housing (45 per cent of the rented accommodation is privately owned and much of that is substandard) are contributing factors. There is evidence to suggest that, in response to high demand, housing agencies, including some from other parts of the country, have contributed to an unofficial housing allocation policy that has resulted in a concentration of people with lower means and sometimes complex needs in Ilfracombe. That policy has not addressed the capacity of the town’s public services and the poor quality private sector housing to host and effectively support those who find themselves living in Ilfracombe.

Investment aimed at reversing this trend had not seen the expected return. One such attempt to improve service delivery brought with it a growing realisation that the way the public sector was organised was hindering its ability to make those improvements. In 2008, Ilfracombe Town Council opened a public services one-stop-shop with over one million pounds of public investment. The facility proved popular with residents improving access to services that were housed there and sign-posting to others. Co-located staff benefited from an increased understanding of the work of other service providers. The factors influencing the population’s health were multifactorial, therefore, people’s support needs spanned a range of services. This new arrangement brought all the pieces of the puzzle on to the same table as it were.

However co-location, whilst improving communication, did nothing to improve coordination of services. If anything, having services housed in the same building merely highlighted the problem as residents expected a more coherent service yet even simple matters seemed to them to be unnecessarily complex.

Parking was one such example. If a parking issue was reported to “the council” at the one-stop-shop, residents would be told it was not the town council’s responsibility. They would be sign-posted to the county council if it was regarding on-street parking, to the district council if it was about off-street parking and to the police if it was a parking obstruction. Even where there was no such split of responsibilities, reporting processes were long-winded and cumbersome with people having to repeat themselves to each agency involved.

However, whilst the town council was able to have a dialogue with the police and other local authorities to attempt to understand and explain the split of responsibilities to residents, there was no such dialogue with health and social care and previous attempts to bring NHS services into discussions had failed. In addition, there were numerous examples of duplicated service provision alongside gaps in the same provision that made no sense to the service user, nor to those trying to sign-post to the relevant service.

The public sector landscape of inward-looking organisations working as islands within the local system was a major barrier to person-centred services. The one-stop-shop was a step in the right direction but to achieve truly person-centred services, providers would need to tackle service fragmentation.

The opportunity
In 2011, the Department for Communities and Local Government (DCLG) announced two community budget pilot programmes: the Neighbourhood level (later Our Place) and Regional level (Whole Place). There were four Whole Place pilots, one of which was Greater Manchester out of which the Manchester Devolution deal was born.

Ilfracombe was one of the 12 Neighbourhood Community Budget pilots supported by DCLG. Each pilot was able to choose their own geography and Ilfracombe was one of two towns, the other ten pilots being located within inner city areas. Ilfracombe Town Council provided local leadership having recently developed a ten-year strategic plan.
The one Ilfracombe programme

The pilot began with service providers joining representatives from the private, voluntary and community sectors with the common objective of forging a system of joined-up service provision that was focussed on the needs of residents.

In April 2013, after a year of preparation and design by representatives from these sectors, One Ilfracombe was formed. Its vision, with three interlinked priority areas, was for “better health, economic prosperity and high-quality living environment in Ilfracombe”.

The scope of this vision was much broader than those of the other pilots, and therefore less focussed, but it recognised the dependencies of the physical environment on the town’s tourism economy, the resulting effect on residents’ ability to find work and live in decent homes and the long-term impact these factors were having on residents’ health.

Organisational form

Having agreed the function of the programme, consideration was given to the form and governance that would best facilitate it.

The legal structure chosen for Ilfracombe’s partnership was a not-for-profit company limited by guarantee with a board of directors from the public sector and six independent directors including local business representatives. Public sector board representation was from the town, district and county councils, clinical commissioning group, police, fire and rescue service, social housing and Jobcentre Plus (with the acute hospital and mental health providers joining later).

Reporting to the board were three multi-sector teams: the Ilfracombe Works Team chaired by a local business leader, the Living Well Team chaired by a local GP, and the Town Team chaired by Ilfracombe’s police inspector.

The independent directors on the board of One Ilfracombe were chosen for skills, not as community representatives. The town council undertook the role of engaging with the community and funded a full time Community Engagement Coordinator to plan and lead engagement with the target groups.

Forming a not-for-profit company provided a vehicle for collective responsibility within the local system. For the first time, the company directors from each of the public sector organisations serving Ilfracombe shared in making decisions at One Ilfracombe Board meetings across the whole system of service provision.

However, this collective responsibility was limited to the work partners initiated through One Ilfracombe. It was not established firmly enough in the governance arrangements of the partner organisations to achieve the robustness required to deliver the ambitions of One Ilfracombe.

Programme principles to overcome the service delivery problems of the past

The years following the creation of the public services one-stop-shop had provided an insight that the reason investment and interventions had not made any significant impact previously was that they generally had three major design flaws. These were:

1. those designing the solutions did not truly understand the problem, tackling only what was obvious to them without understanding the complexity;

2. whilst deep-rooted problems were multifaceted, the solutions were usually one-dimensional, slanted to the perspective of the organisation taking the lead; and

3. the interventions tackled the symptoms, not the root cause, so did not address the determinants of health.
To design out those fundamental flaws in a systematic way, One Ilfracombe developed seven delivery principles that linked integration to person-centred delivery:

1. understand the problem by talking to the people directly affected;
2. redesign the service around the person, not the agency;
3. focus on prevention and reducing demand;
4. develop a coordinated, multi-agency, multi-disciplinary approach and central point of contact;
5. foster community responsibility and support volunteers to help design and provide the solution;
6. establish value for money; and
7. explore potential for One Ilfracombe to commission or deliver services.

Whilst the principles defining the One Ilfracombe model remained sound and nothing emerged throughout the programme to question their validity, there was considerable variation in how each team and project conformed to them. A summary of each principle and the extent to which they were met is provided below.

Principle 1: understand the problem by talking to the people directly affected

This was new practice for Ilfracombe. Despite much attention from local authorities and others due to its stark statistics, investment was frequently secured for projects without ever speaking to the people it was hoped would benefit from them. So projects were designed by members of staff who were well intentioned and able but who had never experienced the challenges facing residents living in the most difficult of circumstances. This lack of real-life understanding resulted in interventions that addressed superficial issues without the insight that revealed a far more multifactorial and complex set of circumstances.

It was therefore agreed that every project would start with targeted engagement with the intended beneficiaries in order to better understand the issues before considering the solution. Engagement to understand current perceptions and gather user and staff experiences fell into the following categories: patient/user/stakeholder interviews, surveys, consultation events, group engagement and staff workshops.

In the first two years, the Ilfracombe Works Team individually interviewed young people classified as not in employment, education or training (NEET) and businesses were engaged through a mixture of face-to-face visits and surveys to establish what support they might need to employ such ones. The Living Well team surveyed 100 older people regarding social isolation and dementia and more than 100 service professionals attended workshops to plan service coordination and consider ways of providing support earlier.

The team interviewed 22 people who had experienced a crisis to find out what points support could have been offered sooner followed by 49 shorter surveys. In total, 45 members of the Town Team attended workshops to establish new ways of working and more than 900 responses were gathered from young people under the age of 24 to capture their views on the support available to them as well as how to improve their involvement in decision making.

By listening to the experiences of service users, we gained an insight into the adverse impact of lack of service coordination on people’s lives. Whilst feedback included responses specific to the engagement subject, a clear theme arose across the public sector spectrum. Residents described feeling frustrated by service silos and bewildered by the number of organisations they were being directed to, each with varying and overlapping criteria for accessing their services with no clear links or pathways.
For example, young people classed as NEET described feeling “passed from pillar to post”, as “just a number”, with the prescribed support not necessarily appropriate to them as individuals. One described how being out of work was distressing, but dealing with the support system was even worse saying “I felt like slitting my wrists at the thought of dealing with any more agencies. The whole benefit thing has been the worst time of my life”.

Staff engagement corroborated the complexity of service provision. In one meeting staff from eight organisations delivering some form of employment support in Ilfracombe expressed confusion over how it all fitted together. This extensive investment in service provision was not making the expected impact as Ilfracombe still had the second-highest percentage of individuals classified as NEET in the county.

A key finding was that in some circumstances, the problem was not lack of service provision, rather that the multiplicity of organisations – including those sub-contracted and charitably funded with no clear links or pathways – was adding to the complexity of service provision. This, in turn, was causing confusion, anxiety, disempowerment and disengagement for service users. Our findings echoed the results of previous studies, but demonstrated that system coordination could significantly alleviate the impact of individual service cuts by joining forces.

This lack of responsibility for the whole of the local system was not only inefficient and counterproductive by making the system excessively complicated, it was detrimental to the public purse in other ways, as one public service worked against another. One 17-year old experiencing mental health issues wanted to continue education but take one A-level instead of three to make the workload manageable. The college was only able to receive its funding allocation if the student took three A-levels so the young person was signed off sick resulting in the Department for Work and Pensions (DWP) funding their benefit payments. The knock-on effect of these decisions taken by one part of the system (education) without consideration of the impact on others (employment and health) was wide-ranging, not least to the young person.

**Principle 2: redesign the service around the person, not the agency**

This principle was intentionally ambitious. It set out to change the way services are delivered, not create additional projects and activities. In that respect the programme as a whole had limited success. Of the three teams only the Town Team, made up of the three councils, police, fire and other related services, succeeded in redesigning their collective service to meet the needs of residents. The Town Team redesigned their access points with an “Any Door is the Right Door” approach. Their ethos was that the team provides an overall “public service”, not multiple service silos, so residents should not have to navigate their way to the right department within this service. Ways of interacting were introduced that were more convenient for the public such as social media chats and text messaging.

By redesigning the way they worked to meet the needs of residents, Town Team member organisations also reaped benefits. They made efficiency savings through sharing a base, reduced travel times by utilising partners’ vehicle storage facilities, and brought a broader skillset into the resources available to them collectively within their day-to-day work.

Some projects were successful in achieving their individual objectives but did not achieve transformational service change. They were less sustainable because they were considered to be outside of core delivery and insufficient consideration was given to how new ways of working would be scaled out across the local system if piloted successfully.

**Principle 3: focus on prevention and reducing demand**

All projects had a prevention focus. To tackle an issue described as “generational worklessness” with its strong association with poor health in the families affected, the need
for interaction with adult role models in early teens was identified with a view to building work-related aspirations. A rolling programme of cadet activity was created with police, fire, ambulance and RNLI officers. The groups of 12- and 13-year olds included children who their school felt would benefit most from the scheme, alongside those needing less support. Two years since the start of the programme, the deputy headmaster commented, “In addition to the attendance and behaviour statistics, we have seen an increase in self-esteem and confidence. A number of these students have taken on leadership roles in the school such as prefects, sports leaders, peer mentors and form reps”. Whilst feedback from all involved has been promising, it is too early to evidence a correlation between this type of early intervention activity and reduction in worklessness.

In the Living Well team, conversations – described as “wobble point” interviews – provided a valuable insight into times in life when people felt they could have been helped to prevent their situation deteriorating. Whilst engagement highlighted tremendous potential to move support upstream to prevent crisis, the Living Well team were unable to translate this understanding into service change.

Two main factors contributed to this failure. First, the size of the pilot meant that service change was difficult to achieve in what amounted to just one-tenth of the North Devon service patch. Whilst the proposed change was about working differently not doing more, the organisational capacity to manage change to the way staff worked in a defined population was limited.

Second, a major stumbling block remained wherever the relevant intervention to address a problem was not the remit of the organisation which would reap the benefits of reduced activity downstream. There was no financial incentive for one organisation to reduce demand for another. This divergence of costs and benefits remained a significant barrier to preventative service delivery.

For example, the Fire Service can show a correlation between their increased preventative work and a reduction in incidents, injuries and deaths. Most public sector organisations, however, struggle to move resources upstream to prevention activity that they believe will result in reduced costs to their own service. Increasing activity that will result in savings for another organisation is even more difficult without a funding mechanism that supports this type of cross-sector prevention activity. New mechanisms are needed that provide organisations with the flexibility to do what needs to be done by whichever provider is best placed to do it, such as increased private sector housing enforcement by local authorities; GPs working with employment services and local businesses; or targeted prevention work by the Fire Service to reduce scalding accidents each of which could result in significant savings to the NHS.

As the earlier example showed, if DWP had funded the shortfall of the funding to the college to enable the young man to have taken his A-level, it would have undoubtedly cost the public purse far less in both the short and long term. Starting with the premise of what would best help an individual, rather than what works best for an organisation would almost certainly achieve the latter anyway.

As implied by the name, there was an expectation from DCLG that new ways of working devised by the Neighbourhood Community Budget pilots would be facilitated by pooling budgets. None of the pilots achieved this. One Ilfracombe’s attempt progressed as far as developing a system that allowed for all public sectors spending to be identified (in varying degrees of accuracy) down to town level through the development of its Virtual Bank. However, despite accounting for an annual spend of approximately £82 million it was difficult to gain agreement from the partners on how to use this information to pool funds which were budgeted for shared objectives. This may have been due to Ilfracombe not being large enough to warrant such transformational change, and the “Virtual Bank” not being viewed as a test of change for potential scaling up across
the county. In the end, programme leaders decided that pooled budgets were not necessary for coordination and integration of services. It is worth noting that this conclusion was reached more as a result of inability to implement a pooled budget rather than an objective assessment of value.

Principle 4: develop a coordinated, multi-agency, multi-disciplinary approach and central point of contact
Unlike the other teams, the Town Team chose coordination and integration as their primary objective rather than tackling a specific service issue. They felt that integration was more than enough of a task in itself and that integration alone would improve the service each organisation provided. This hypothesis was confirmed by early evaluation which showed that 85 per cent of all issues reported were resolved within three hours, with the same types of issues previously taking up to three days to resolve.

To support integration, a shared base was created at the Fire Station and when reporting for work in Ilfracombe, team members sign in on a shared radio system so everyone knows who is available. Residents can ask for advice or report a problem to anyone wearing a Town Team armband, whichever organisation they belong to and whichever is the best placed to deal with it does so, whether within the remit of their employing organisation or not.

This blurring of organisational roles worked because everyone took responsibility and whilst some issues continued to be managed in the traditional way, wherever possible the Town Team worked flexibly. Building on this success a new role was created integrating the roles of a police community support officer and a retained firefighter.

In the Living Well team, conversation events were held with over 100 of Ilfracombe’s health and social care staff and others with a role in residents’ wellbeing. It transpired that most were unaware of the other support available to their patients whose needs spanned other services and opportunities for earlier intervention were being overlooked.

Whist some practical steps were taken, such as training to identify triggers for partner referral, staff suggested that they too needed to use the services of the Community Connector, a post that had been created as a result of the feedback from older residents in the work to reduce social isolation. The need for organisations to use a connector highlights the failure of services to become more connected and the Living Well team found implementation of this principle to be the most challenging.

It became clear as the programme progressed that coordination worked best when the partner organisations had a level of local autonomy and where managers gave permission for operational flexibility (Williams, 2007; Kaehne and Catherall, 2013). On the other hand, collaboration became problematic when organisations only had flexibility outside of their core service, or organisations were sub-contracted to deliver against outputs that stifled their flexibility.

Principle 5: foster community responsibility and support volunteers to help design and provide the solution
The programme generated volunteering opportunities as a result of the gaps identified during engagement. These ranged from sixth form students helping older people to interact with family and friends online; retired residents forming a club to use their practical skills for needed projects; employers helping students become “work ready”; a pub hosting a social afternoon for people with dementia and their carers with entertainment provided for free from the museum and local singers. Businesses became “dementia friendly” and when asked if a street wanted to test out a “community health watch” scheme, a whole village came forward and formed a Good Neighbours Scheme to support their vulnerable neighbours.
The readiness and capacity of residents to give their time and individual expertise to help others in their community demonstrates the often underestimated value of the “renewable energy” referred to in the NHS Five Year Forward View.

An asset-based approach seeks to understand and capitalise on the capacity of its own residents, its own businesses and its existing good work. It was apparent from the one-stop-shop that some services had been funded to target a particular issue, but no account had been taken of what may already have been in place resulting, not only in the aforementioned duplication and confusion, but also potentially destabilising existing provision. The scale of One Ilfracombe was well suited to an asset-based approach which could potentially unlock the “community value” that is often overlooked by service providers.

**Principle 6: establish value for money**

Funded by DCLG, NEF Consulting was commissioned to assess the robustness of One Ilfracombe’s integrated service model and its potential for cost savings.

They reported that the Community Connector would need to successfully address approximately 30 social and care “needs” per year, over a two and a half year period, if the benefits were to exceed the costs. Any additional successful provision would mean the Community Connector was a net contributor to the public purse. Of the 106 people seen by the Community Connector in the first year, 245 issues were dealt with, of which 176 were successfully resolved.

The NEF report concluded “The One Ilfracombe model provides an inspiring and participatory response to the tightening of public purse strings, by seeking to use the strengths of everyone working within the town to make positive impact go further”.

Whilst focussed on savings as a result of reduced demand through earlier interventions there was also a drive for greater productivity and efficiency which was achieved through the sharing of space, equipment and people although, for the most part, this was only achieved in the Town Team.

The difficulty the programme team encountered when trying to demonstrate value for money and effectiveness was lack of common criteria for what constituted value or success, in particular when looking at prevention-focussed activities. If we are to learn from the many different approaches to integration being taken around the country, a common evaluation process needs to be agreed nationally. Assumptions regarding the causal relationship between integrated services and cost savings need to be more fully tested.

**Principle 7: explore potential for One Ilfracombe to commission or deliver services**

The theory behind this principle was that if pooled budgets were not achievable, then local commissioning by One Ilfracombe on behalf of partner organisations might achieve similar benefits. It also highlighted the potential for One Ilfracombe to deliver a service commissioned by partners which would contribute to the long-term viability of the model. The Community Connector was the only service delivered by One Ilfracombe that was commissioned by three of the partners from health and social care. As with other aspects of the programme, to ensure its sustainability, the commissioning and evaluation needs to considered on a wider scale and the success extended to those other communities in North Devon that have expressed the desire for a Community Connector.

**Discussion**

Ilfracombe’s example demonstrates why simply focussing on health and social care services does little to tackle the underlying problems that lead to poor health outcomes. People’s needs span many public services and the action or inaction of individual service providers causes reactions within the system that impact on people’s lives.
These difficulties only become fully apparent when the time is taken to speak to individuals to get a deeper understanding. Where the entire system that supports people is viewed as a whole, from the viewpoint of the citizen, the failures and opportunities within the system become clearer.

Four years since its inception, One Ilfracombe continues to receive the support of its partners and most of those involved are convinced it is the way forward. But a critical review of the programme’s outcomes against its vision of “better health, economic prosperity and high quality living environment” reveals that Ilfracombe’s public health problems are as stark as ever. As international evidence shows, it is probably too soon for such a prevention-focused approach see such an impact (Hildebrandt et al., 2010; Kaehne, 2016). In addition, the approach has not yet been fully tested due to the One Ilfracombe’s failure to fully deliver against all of its principles across the entire programme.

The value of One Ilfracombe to the partners delivering services in Ilfracombe is evident, but key to its sustainability will be its ability to be scaled out and this is yet to be tested. A sustainable financial model that considers collective resources and shared outcomes needs to be developed on a larger scale and the programme leads anticipate this to be the next stage covering a population of seven towns.

An often mentioned facilitator of successful collaborative work is systems leadership. Whilst collective leadership was required, significant individual skills were also needed to launch and lead One Ilfracombe through its first years and this proved challenging to sustain at a local level in a volunteer capacity. A larger geography and remunerated position would increase the viability of this.

When considering all of the above, it becomes clear that the main contributor to both the success and failure of One Ilfracombe to implement its principles is the size and scale of the programme.

**Local vs regional**

There are clear advantages to initially taking a local approach as opposed to engaging in wholesale regional service integration. Co-design with local staff brings immediate traction and a programme designed specifically with the local context in mind, using the assets available to each community (people, places, buildings, service provision) and capitalising on the commitments of local people to their own neighbourhoods. In addition, by limiting the size of the population to that of medium-sized town, the whole breadth of service provision can be included.

However, a wider supporting infrastructure is required to support such a local place-based system, which facilitates the level of transformational service change required and a finance mechanism such as a pooled budget in order to address the prevention agenda. Without this alignment of bottom-up and top-down approaches, the benefits to a local area will struggle to be sustained and expanded.

**National infrastructure**

Furthermore, in order for important bodies to be involved who have little flexibility within their core services, such as DWP, and to prevent a patchwork quilt of service provision across the country, national drive and support is also required.

Cross-departmental models for communities to use which incorporate and are supported by all public services do not exist. Whilst government departments and national bodies whose services cover health, social care, housing, benefits advice, police, fire and community services have shown leadership within their own sectors in promoting ways of joining up, such as with the NHS’s Sustainability and Transformation Plans, these initiatives are mostly led independently by individual departments without clear joined-up direction from all parts of the public sector. This can result various coordination initiatives taking place in
one geographical area each competing for the time and resources of the same participants. This is not helpful for creating integrated services across the public sector and the learning from each is not maximised.

Conclusion
In the past, we have tried to implement solutions without a real understanding of the problem, we have designed and implemented those “solutions” in silos, not systems, and we have tried to tackle the symptoms, not the cause. We have accepted the landscape of complex and fragmented public service provision as the one we are stuck with – even though we know it hinders service users – because numerous policy attempts over at least the last decade have failed to change it.

The public sector needs to become less puzzling to those it serves if it is to be more effective in tackling entrenched problems. It needs to join up all the pieces of support available to improve people’s health including those that improve social, economic and living environments if we are serious about prevention and reducing inequalities.

It is illogical and unreasonable to expect this integration to be managed independently and variably at community level. Therefore considerable national leadership is needed to develop a cross – Departmental Integration Programme that provides clear and consistent support and evaluation whilst allowing for and valuing the individuality of communities and the capacity of local teams to find local solutions.

References


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