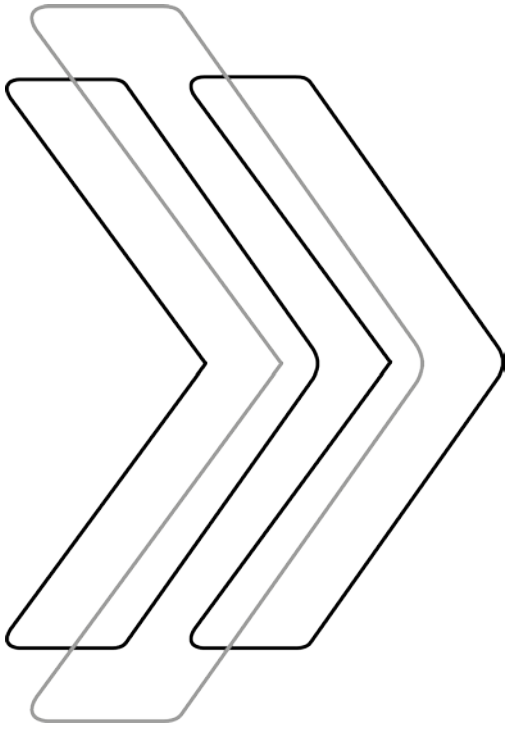
Supporting integration

Workforce considerations
Roundtable discussion



The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

www.kingsfund.org.uk **@thekingsfund**

Contents

Introduction

This roundtable event was set up to review the findings of the report *Supporting integration through new roles and working across boundaries*, which The King's Fund had produced independently with support from NHS Employers and the Local Government Association. Participants (see list in Appendix 1) had been invited for their expertise and experience from academic, policy, professional and service delivery perspectives.

The meeting was structured to discuss the report's findings, to consider two case studies that would illustrate how they played out in real life, and, in small group discussions, to propose issues and possible actions for NHS Employers and the Local Government Association to consider.

Supporting integration through new roles and working across boundaries

Helen Gilburt, author of the report, presented its main findings. The report set out a review of published literature and brought together the available evidence in order to inform further thinking, rather than making recommendations. It was commissioned in parallel with a recently published report by the Nuffield Trust, *Reshaping the workforce to deliver the care patients need*, which set out practical guidance for those wishing to reshape and 'grow' the workforce in NHS organisations. Both reports would help inform NHS Employers and the Local Government Association as they assessed opportunities and implications for the workforce of continued moves towards integrated care across organisational and professional boundaries.

The review of literature had found a wider range of evidence than had originally been expected. It aimed to clarify the types of roles that had been developed, what they had achieved, and what barriers or success factors had been identified. However, the evidence relating to achievements was less extensive, as in many cases it related to evaluation of integrated care projects rather than of individual staff roles within those projects.

Participants welcomed the report, and there was widespread agreement with its findings. In discussion the following points were raised.

- There was strong support for findings that related to the need for team and organisational development to support integrated care, rather than focusing just on individual roles. There was also strong support for findings on making full use of existing skills and capabilities rather than assuming a need for new roles.
- The report only reviewed published literature, and it acknowledged that there were gaps in the literature. In particular, more evidence would be valued on the cost-effectiveness of new roles (in particular, benefits to the health and care system as a whole rather than to individual organisations), the role of the non-statutory sectors in developing new roles, and roles that span boundaries between children's and adult services.

- It was also noted that some ‘grey’ literature, for example in relation to local authorities’ in-house training and staff development, would not have been available. Increasing the availability of evidence on local projects might help to identify good practice.
- The need to develop better evidence on cost-effectiveness and long-term sustainability were themes in the discussion. In both areas, there were practical difficulties to overcome. In order to measure cost-effectiveness, there would be a need to understand how to measure outcomes of care and how to ascribe the causal relationship to new roles. In order to achieve sustainability, there would be a need for better resources to model expected need and related resource requirements.
- There was a general recognition that new roles were likely to increase rather than reduce costs, at least in the short-term. This was because many new roles involved high levels of capability in working across boundaries, and so were likely to be at relatively high levels within pay bands, and because where new roles were effective, they were likely to increase uptake of services and reduce the likelihood of people falling between ‘gaps’ in services. Further evidence on how to measure costs, and on practical steps to contain or offset them, would be valued. It was noted that this may mean some services having to stop, in order to free up resources for developing new roles.

Case Study One: Cheshire Pioneer

Guy Kilminster gave an overview of the Cheshire Pioneer, which was one of the original integrated care pioneer sites established in November 2013. The pioneer programme covers two local authorities and four clinical commissioning groups, along with several acute, community and mental health trusts and adult social care providers across these areas.

The pioneer model comprises an overarching governance structure, a delivery structure, five workstreams and a series of enabling factors. The workstreams include:

- community and integrated care
- empowerment – working to empower both service users and the workforce
- continuing healthcare – a workstream incorporated into the pioneer from previous work
- integrated digital care record – with an aim to include all care settings
- mental health – development of integrated commissioning between the CCGs and local authorities.

Workforce components

As well as a core element of empowerment, the workforce is identified as a key enabler of integrated care. The focus on workforce in the Cheshire Pioneer has been on enhancing workforce development, including the following workforce initiatives.

Connecting Learning and Improvement Academy – recognition that across the Cheshire Pioneer many different learning and development offers are being commissioned leading to duplication and siloed working. This piece of work maps what is being commissioned and considers how to join these up.

Career and Engagement Hub – recruitment and retention are areas of particular pressure for providers in the pioneer. This includes domiciliary care staff, general practitioners and hospital consultants. This programme aims to support a systematic approach to recruitment and retention, reducing competition among providers in the area for staff, identifying where there are gaps and suggesting means to fill them.

Integrated Team Management – rather than developing new roles, the pioneer has supported integration by creating an overarching 'integrated team manager' role, which brings together the different staff teams and reports to both the local authority and the NHS. Each area identifies the specification for this role and who holds it.

Workforce Workstream Project – this programme of work is supported by funding from NHS England. The first part of this work has involved developing an online tool called the Workforce Repository And Planning Tool (WRAPT), which collects workforce data, including organisation, department, role, cost-centre and salary, as well as demographic data related to protected characteristics on staff across health and social care. The tool aims to produce a baseline document that forms the basis for workforce scenario modelling and long-term workforce planning.

The second part of this work has been a consensus exercise to examine the type of support that staff and organisations require in relation to integrated care.

Other areas of workforce integration

A number of additional workforce solutions have been implemented to support integration. One of the most notable in the mental health workstream has been the development of integrated commissioning, but others included the development of team approaches including a dementia re-ablement team, and the location of a local area co-ordinator in each GP practice to connect the practice with care homes in the locality.

Key lessons and challenges

One of the main lessons that has emerged from the pioneer is the considerable time and investment that is required at both a strategic and practical level. Joining up care and creating integrated solutions requires all parties to agree not only on the vision, but importantly on how it is achieved. In practice this has often meant negotiating agreement between individual providers and organisations on issues ranging from contracts and data-sharing protocols to individual job descriptions.

A core part of this was achieving consensus. The examples that Guy shared emphasised that this is an active process and that all parties involved need to remain committed but flexible – there isn't a 'one-size fits all' solution. In retrospect, one lesson was that the scale of the pioneer had perhaps been ambitious and that achieving consensus among stakeholders might have been easier within a smaller geographical area.

Part of this process was the need to change culture and behaviours. One particular challenge was to balance the requirements of the system and of the organisation. The depth of that challenge was reflected in a recognition that this is not just about culture at the top but that cultural and behavioural differences were overt at all levels from individual teams and departments to organisations.

The Cheshire Pioneer highlights both the importance and potential of data-sharing in supporting integration and also the considerable challenges in achieving this. The pioneer had made considerable advances in creating data-sharing mechanisms, but the administrative processes required liaison with each organisation's data controller and authorisation of data governance arrangements, often requiring the written agreement of all parties before the data could be shared.

Each of these elements is interlinked, but perhaps the underlying message was the need for capacity to 'drive change relentlessly and robustly'.

Opportunities in going forward

It is clear that the pioneer has made clear steps towards systems integration and, importantly, in establishing good relationships for future work. They identified mechanisms to facilitate the changes identified and to maintain momentum. For example, a new project in Lancashire to develop an online information-sharing gateway offered potential to streamline the administrative tasks associated with data-sharing agreements, while it was hoped that the forthcoming sustainability and transformation plans would seek to develop alignment with the integration pioneer and other initiatives in the area as well as driving forward change at scale and pace.

Finally, with so many new initiatives and information available, the value of synthesising evidence to inform practice and to avoid 'rabbit holes' for organisations engaged in transformation was re-stated.

Case Study Two: Greenwich Co-ordinated Care

Jana Krohn presented the Greenwich integrated care programme, which began in 2011 by developing a number of integrated service models across institutions. One of the limitations of this approach, however, was that integration at a systems level had not necessarily led to integration of staff at the 'front line' of care as experienced by individuals Greenwich Co-ordinated Care had been established to create a model based on the co-ordination of services around the needs of individuals. The pioneer is a cross-agency partnership including the local

acute, mental and community trusts, the CCG, local authority, a consortium of local voluntary and community sector organisations and local Healthwatch.

They aimed to build on what works, and adopted an action learning approach to achieve this. Staff had reported that despite co-location they had seen little change in ways of working, so they contributed to a series of workshops developing practice. In addition, staff kept a learning log, which formed the basis of a 'test and learn' approach: when something was identified as not working, staff were encouraged to consider and implement ideas of what would work. A core element of this was focusing on the working relationships, having shared values, aims and views to deliver person-centred care, and staff being 'given permission to think differently'.

Greenwich Co-ordinated Care focused on people at high risk of unplanned admission to hospital as identified by a local CCG, using nationally recognised risk assessment tools.

The care navigator role

Part of this service included a care navigator role. The role is the first point of contact for service users and carers and is responsible for bringing together professionals from across the health, social care and voluntary sectors to deliver a care package: this package is developed with the service user and carer using the 'I' statements approach. The care navigator convenes a monthly multi-disciplinary meeting including core team members and professionals as required from each GP practice in the borough to support care planning. Once a plan is in place, the care navigator is responsible for liaising with the service user and following up with the relevant professionals.

Quite quickly it was recognised that this is not so much a service but a way of working, which required a change in behaviours and culture to ensure that pathways and services are delivered based around a person.

Staff in this role have experience in both health and social care, and the role is underpinned by a competency framework that includes communication, administrative, organisational, multi-disciplinary working and networking skills. The team is supported by 'in house' sessions from across the multi-disciplinary team, and a focus on different ways of working from motivational interviewing to conflict resolution.

Key lessons and challenges

One of the main outcomes of this approach has been the flexibility that has resulted from breaking down the barriers between staff and focusing on a common goal. As staff have engaged with different organisations and professions they have increased their understanding of different organisational cultures and language and their knowledge of what other organisations do. Importantly, this has also strengthened professional relationships and enabled greater richness of care planning, which are felt to make the investment of time and effort worthwhile. As a result, staff have been empowered to identify what they can do themselves, rather than relying on formal referral processes; staff also report greater use of voluntary and community sector resources.

Furthermore, the involvement of GPs and GP practices has also served to sustain a whole-system approach.

Opportunities in going forward

The experience of Greenwich Co-ordinated Care has been very much one of development, learning and evolution over several years, and their narrative for the future reflects this approach. The next steps include building on the approach to develop anticipatory care plans for those who are at risk of unplanned hospital care as a means of reducing A&E attendances.

There is also recognition that in supporting sustainability the approach itself will need to evolve, moving towards creating wider integrated leadership and moving from a standalone team to merging the care navigation approach into the wider integrated teams model.

Table discussions

In order to facilitate discussion, sharing initial thoughts and identifying areas where future support would be most valuable, participants split into four tables each addressing one key issue identified from the report.

- Table 1: Key challenges in developing new roles to support integration
- Table 2: New roles versus working differently
- Table 3: The role of national bodies and systems of support
- Table 4: Integrating across the boundaries of health and social care

Discussions across the tables covered four main themes.

Considering new roles

Although there was widespread agreement with the findings of the report, the group also recognised that you could not stop new roles being developed at a local level, but that organisations needed to recognise the shortcomings, understand common considerations around workforce redesign and development, and balance sustainability of workforce solutions with the flexibility to respond to emerging needs and subsequent organisational change.

Enthusiasm for new roles without full analysis of need.

There was a shared view that few totally new roles were likely to be needed in a service, and that there had sometimes been a tendency to over-state the extent to which roles are new. Alongside this was a recognition that the scale of development around new roles wouldn't meet the ambition of what is needed to change care and that new roles should certainly not be considered a 'magic bullet'.

It was noted that the two case studies (Greenwich and Cheshire) presented clearly new roles of care navigators and integrated team managers respectively, but beyond that their emphasis was on bringing together existing roles to work more closely and flexibly. In general, this was felt to be appropriate and that large numbers of new roles were unlikely to be needed if there was a careful analysis of what skills are needed, whether those skills exist in the workforce and, if so, how they could be deployed to meet people's needs.

Re-inventing the wheel

When new roles are established, there are significant predictable practical considerations, including:

- agreeing job descriptions and terms and conditions across organisations
- clarifying accountability
- understanding implications for career progression
- sharing information across organisations to support the new roles
- developing training in key skills for working across systems and professions.

It would be useful to have guidance on a process that could be followed to identify the need for and design of new roles. In particular, it was felt that a structured tool would be helpful to guide services through setting out in detail what they are seeking to achieve; what skills it will require; what skills are already available in the workforce and what gaps there are; options for filling those gaps; and the impact of filling the gaps on existing roles and services.

There is also a need to get better at disseminating good practice so that others can learn from it – for example, the workforce repository and planning tool that had been developed in Cheshire. Equally, it was felt that there may be common pitfalls that others could be helped to avoid. For example, creating unsustainable job designs in which too many new features are wrapped up into one job on top of existing responsibilities; or creating new roles to fill an identified gap without first reviewing the skills available in the workforce and maximising opportunities for using them differently.

Need to allow time for new roles and new ways of working to become established

While much of the discussion – and, it was thought, much of the literature – concerned the early period of establishing new roles, it was felt that a significant issue was how the new roles develop over the long term and become embedded. This was potentially more difficult than establishing new roles, and there were numerous anecdotal examples of new roles that had lost their initial momentum and failed to become embedded. Particular concerns were the difficulty in making a case for investment in new roles when their sustainability was not assured and the difficulty of demonstrating cost-benefit rigorously (especially in terms of impact on clinical outcomes).

On the other hand, it was felt that new roles would inevitably evolve, that this could be a positive process and it should not be assumed that once established they should remain 'as is' forever more. This line of discussion was linked to the previously mentioned themes of over-enthusiasm for new roles and overcoming inflexibilities. Some new roles may not be strictly necessary in the sense that a rearrangement and different use of skills already available in the workforce could in theory be sufficient. However, in practice, that rearrangement sometimes requires the creation of new roles, which may not endure but could help to break down barriers to integrated care and lead on to new ways of working that can become embedded. This discussion was speculative, but was underpinned by a clear view that those leading the establishment of new roles should be prepared for them to evolve and should work with that evolution flexibly rather than defensively.

Working across boundaries

It was evident from the discussion that the different systems in play, from budgets and workforce development to governance, often served as barriers to more integrated working and that alignment of these factors could support a common agenda across different organisations.

Aligning systems, processes and practice

The need to develop and align systems and processes was highlighted as key to supporting integration. Funding was noted as a particular area of focus. For example, local authority funding is defined by eligibility and often underpinned by specific, finite funding streams; this can run counter to the ethos of universal services of the NHS and make it difficult to agree how to work together (although it also ensures that costs are based on local needs, which ought to be a shared priority). Some organisations, such as those involved in the Greater Manchester devolution programme, had pooled budgets, which had been beneficial to integration, for example in ensuring that the money follows the person. However, the legal frameworks place restrictions on doing this more widely, and some areas had reported difficulty in pooling funding from health and social care budgets. There were examples of integrated care for particular populations that had been achieved without the pooled budgets, but questions remain about what happens in the 'grey areas' of integration.

Alignment of systems and processes was also important in relation to the workforce and workforce development. Aligning employment terms and conditions was identified as important but difficult, and the opportunities for alignment of policies were highlighted. Furthermore, in developing joint initiatives to support integrated working, it was important to ensure that processes were appropriate to all stakeholders. Examples of joint training between NHS and social care staff that failed to properly reflect the context in which social care staff would implement care were described as unhelpful; as one participant noted 'Adult social care providers don't want NHS solutions transported in'. The potential of using evidence-based approaches across both sectors in order to drive integration was considered. The importance of adapting systems alongside workforce development was noted; failing to do this could result in staff being unable to implement new ways of working.

The value of focusing on patients in driving integration was highlighted. Undertaking assessments of patients' needs will help organisations to work out who is needed and best placed to provide care for individuals; service users have a mix of health and social care needs and can't be pigeonholed. Risk stratification also offered opportunities to drive integration, but having good data was an important step in this process.

Governance

A key consideration in creating integrated solutions across health and social care was the nature of governance. Governance is essential in areas such as managing the HR processes involved in establishing new roles and in setting up agreements, systems and processes for information-sharing and for common assessments.

Achieving agreement across organisations, however, often meant taking into consideration different governance processes. In local authorities, for instance, decisions by individual officers leading integration required agreement from a wide range of people, sometimes including councillors. In some cases this meant that local government was less agile in decision-making, and in others there was a lack of political appetite for integration. Although health and wellbeing boards set the strategic direction, they were not always seen as effective in providing a catalyst for integration.

Leading integration

The leadership 'task' associated with integration cannot be underestimated. Many of the activities reflect generic leadership skills, but what was unique about leading integration was the ability to create consensus. The value of stable leadership to build trust and relationships and to see through change was a core component of this.

System leadership

One of the key issues with developing an integrated solution was the ability to move from a shared vision to a shared plan of action. Participants noted that there was often agreement at the initial stages on a broad approach, but that this fell apart when it came to agreeing how this would be achieved. Asking organisations to model the consequences of different approaches was suggested as a mechanism for engaging them.

The question of what integrated care meant in practice was discussed – whether it required full organisational integration or could be achieved by organisational alignment. A range of approaches were shared: those involved in the Greater Manchester devolution programme had adopted pooled budgets and risk-sharing agreements; the accountable care model was mooted as potentially aiding alignment while allowing individual organisations to deliver on different priorities; and finally there were examples of health and social care staffing being contracted under a single provider (eg, a joint venture, or creation of a social enterprise).

A further tension in developing plans for integration was the extent to which organisations should or could adopt a single approach across a geography. Commissioners were noted as often being

supportive of doing things differently, but each keen to each pursue their own approach. This was a particular issue for areas in which the geography of CCGs and the local authority were not co-terminous. In a similar vein, despite consensus on the need to do things differently, organisations often saw this as doing things differently within their own organisation and budgets, rather than more broadly and across organisations.

One of the key take-home messages was the importance of leadership in the process, in playing a key role from the outset and in forming a whole-systems vision. However, there was recognition that in creating a shared vision, we also need to ensure the language reflects a shared narrative on the nature of integration. The challenge of managing acute needs and high costs was not solely an issue for the NHS, and this needs to be reflected.

Leading change on the ground

Discussion highlighted the importance of leadership at all levels for new roles and new ways of working – not just at corporate (organisational) level, but in particular also at team level and at system (local health economy) level. This was essential for new roles or ways of working across boundaries to become established within the mainstream of service delivery.

The leadership activities required included negotiating, influencing people to adopt a clear vision, freeing up capacity to develop new ways of working, and supportive coaching of staff. In addition to these 'generic' leadership activities, leaders had a role in:

- empowering and encouraging staff at all levels to think differently and innovate
- promoting a culture in which there would be a readiness to adapt services around patients and service users' needs rather than around established professional roles and identities.

This was particularly important as much of the evidence around integrated care demonstrated that its success was dependent on behaviours and ways of working, not organisational form.

Another important requirement for leaders was to oversee the process for the long term, to allow for evolution and embedding; to treat changes in roles and ways of working as part of a culture change that put people's needs above professional identities; and for that culture change to include patients and service users as well as staff (for example, to influence expectations of always seeing the doctor).

Commissioners had an important role in leading the approach to (as well as the funding of) strategic plans for services in their area. Sustainability and transformation plans (STPs) were also noted as having the potential to lead strategic service development across an area in this way, and also to pilot and evaluate new services and new roles. Transformation funding could help to resource this, and the infrastructure being developed to support service transformation across the NHS could help with roll-out and dissemination.

Breaking down silos

In considering how to integrate care, the discussion also focused on how far siloed working itself contributes to a lack of integration and how this could be addressed.

Overcoming inflexibility and silo working

One of the common issues with new roles or new ways of working is that professional territories and identities can be inflexible. This was felt to be well covered in The King's Fund report, and additional points in the discussion drew attention to the roles of:

- professional regulators (and to some extent, system regulators too), whose requirements may not fit with new roles and could therefore discourage them
- professional colleges and educators, who are influential in establishing a sense of professional identity and territory both directly (eg, in how they teach roles) and indirectly (eg, in how student placements are designed and where they are allowed).

Reaching the social care workforce

A particular factor raised in relation to integration was the nature of the relationship between local authorities and organisations providing social care support. The link between the local authority and social care staff depends on whether staff are directly employed by the local authority, are employed within services that are commissioned, or are employed in services that the local authority has an obligation to secure through its role in market oversight (ie, avoiding the unplanned management of the consequences of financial collapse of certain providers). These different relationships influence the extent to which local authorities are directly or indirectly able to influence the social care workforce. A further question considered was the extent to which the workforce within private sector organisations that are in receipt of public funding are part of a wider integration agenda.

Metrics which advocate for integration

One challenge to integration was the way in which outcomes were measured. The focus on reduction in A&E admissions was highlighted as creating inappropriate focus on health, and in particular on acute service outcomes, at the expense of outcomes that reflected the value of other sectors and, importantly, that were meaningful to service users. In addition, measurements of success such as reduced residential care admission often focused on negative outcomes, eg, avoiding admission. The importance of using measurements and targets that aim to encourage system-level working rather than those that are specific to individual organisations was highlighted, while the value of presenting metrics in positive terms, such as enabling people to remain independent and in their own home, could facilitate a more holistic response, enabling organisations to consider their role and contribution to achieving this.

Reflections from the discussion

In summing up, Danny Mortimer, Chief Executive of NHS Employers, and Jon Sutcliffe, lead for the Local Government Association workforce strategy team, gave their thoughts on the presentations and subsequent discussion.

A number of areas have been identified as priorities for further work at national level:

- the vision for services is still not clear or agreed in some areas
- as the case studies demonstrate, this is not just about organisations and structures, it's about changing behaviours and cultures.
- developing a consensus is one of the major leadership challenges.

There is some work to be done on agreeing the clarity of purpose around integration, developing guidance to help understand points of overlap between organisations involved in integration – particularly between health and social care – and in supporting engagement of frontline staff.

Discussion has further highlighted the need to consider the roles of providers as well as commissioners in the integration agenda. The identity of the NHS and social care (whether this is social work, or roles in the wider social care workforce) also requires further consideration, and there is the key issue of relationships between health and social care, from the Local Government Association and NHS Employers to organisations on the ground.

What is needed to support integrated care, and the role of the workforce as part of this, is to further articulate the strength and depth of the challenge ahead.

There is a need to challenge some of the 'received wisdom' and putting money into individual initiatives and a requirement to focus on behaviours, team-working and achieving true integration.

The challenge of understanding the true cost-effectiveness of integration remains, and there is a need to support and develop the business case for workforce development. One priority must be skills development across the workforce including what it means to work in a team and enhanced teamwork. Enabling people to work differently will require investment in developing their skills and competencies as well as developing processes, and there is a need to understand how best to approach this.

In commissioning this work and co-sponsoring the roundtable, the Local Government Association and NHS Employers are reflecting their commitment to joint working in this area, but there is a balance between what can be achieved by a top-down approach, which despite best intentions can lead to adverse drivers in the system, and the need to support local development. As such, the Local Government Association and NHS Employers have an important role in developing together the 'context' to support local integration, including support for information-sharing,

skills development, and collaboration to enable more flexible working arrangements across organisations.

Workforce challenges and recruitment are issues for both the NHS and social care sector and may have become even more prominent in the current political and economic situation. Getting a handle on workforce development, ensuring that skills development meets future needs, and matching up the skills of the workforce with the demand will be key factors in ensuring further progress towards an integrated health and social care system of the future.

Concluding statement from LGA and NHS Employers

LGA and NHS Employers are committed to working jointly wherever we can and will keep people informed of developments around this important agenda. We hope The King's Fund report and the write-up from the roundtable will support local joint action.

Appendix

The following participants attended and contributed to the discussion.

Patricia Coker	Main Lead for Integration and Workforce at Central Bedfordshire Council
David Foster	Deputy Director of Nursing, Department of Health
Guy Kilminster	Interim Director Cheshire Pioneer Programme, Cheshire East Council
Maria Lagos	Director of Sector Development – Innovation, Skills for Care
Jill Manthorpe	Director, Social Care Workforce Unit, King's College London
Claire Goodman	Deputy Director, East of England Collaboration for Leadership in Applied Health Research and Care
Damian Hodgson	Professor of Organisational Analysis , University of Manchester
Paul Roche	Workforce Programme Director, Healthy London Partnership
Raina Summerson	Chief Executive, Agincare
Jackie Campbell	Senior Workforce Consultant, Change & Workforce (People)
Caroline Corrigan	Workforce Lead at NHS England for Vanguards
Colin Lindsay	Reader in HR Management, University of Strathclyde
Candace Imison	Director of Policy, Nuffield Trust
Christina McAnea	National Secretary, UNISON
Mary Hill	Better Care Manager (South East)
Alex Baylis	Assistant Director of Policy, The King's Fund
Richard Murray	Director of Policy, The King's Fund
Helen Gilburt	Fellow, The King's Fund
Jon Sutcliffe	Workforce Strategy and Consultancy Lead, Local Government Association
Rebecca Smith	Director of Engagement, NHS Employers
Danny Mortimer	Chief Executive, NHS Employers
Paul Taylor	Assistant Director (Organisational Development), NHS Employers
Anne Greenwood	Head of Integrated Intermediate Tier Services, Bolton NHS Foundation Trust & Bolton Council
Matthew Kendall	London workforce lead, Association of Directors of Adult Social Services
Jana Krohn	Integration Lead, Greenwich Co-ordinated Care