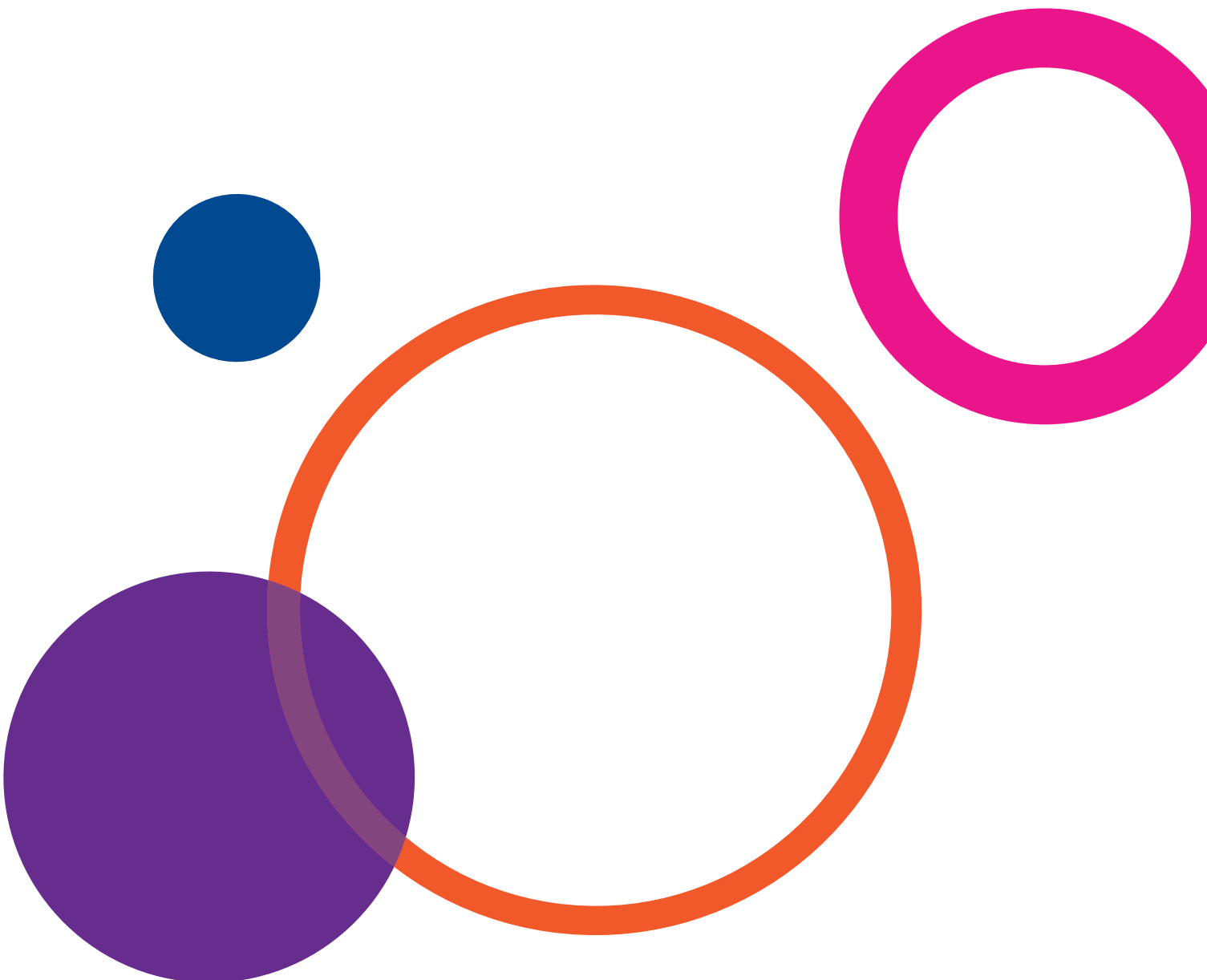


From place-based to place-led

A whole-area approach to
integrating care systems



What is the Integrated Care Systems Network?

A critical part of delivering the ambitions of the NHS Long Term plan will be empowering local systems and giving them the autonomy they need. At the NHS Confederation, we are supporting emerging systems and helping local areas on the journey to becoming integrated care systems by April 2021. We believe the ambitions of the plan can only be met through greater collaboration, partnerships and system working.

We are undertaking a number of activities to support local systems. Alongside tailored support for ICS/ STP independent chairs, programme directors, clinical leads, mental health leads, workforce leads, non-executive directors and lay members, we have now established a national network for ICS and STP leaders. This was set up in response to feedback from ICS/ STP leaders across the NHS and local government who told us they wanted an independent safe space to exchange ideas, share experiences and challenges, and develop solutions. We are also producing a series of case studies on key topics with practical learning for STP/ICS leaders.

Stay in touch by:

- contacting your regional lead – see page 39 for details
- signing up to our Integrated Care Bulletin by subscribing at www.nhsconfed.org/newsletters
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About the NHS Confederation

The NHS Confederation is the membership body that brings together and speaks on behalf of the whole NHS. We represent over 500 members across health and social care, including hospitals, community and mental health providers, ambulance trusts, independent sector organisations providing NHS care, and clinical commissioning groups.

We have three roles:

- to be an influential system leader
- to represent our members with politicians, national bodies, the unions and in Europe
- and to support our members to continually improve care for patients and the public.

All of our work is underpinned and driven by our vision of an empowered, healthy population supported by world-class health and care services; and our values of voice, openness, integrity, challenge and empowerment.

To find out more, visit www.nhsconfed.org

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Key points

- This paper describes the essential role of place-based approaches in taking forward the NHS reform agenda. Based on interviews with senior leaders, it seeks to provide further insight into how local systems can make progress in designing and delivering place-based, integrated care. In particular, it describes what system leaders can do to make this happen.
- A key enabler for place-based working is having a clear framework and set of guiding principles for the scope of work and decision making at each level of the wider system. Knowing what happens where is instructive in determining who is involved in decision making and which governance arrangements are most appropriate. This clarity supports distributed leadership, devolved powers and shared accountability.
- Place-based partnerships often start with a 'coalition of the willing', with local government playing an important leadership role. This creates the energy and capacity to co-produce a shared vision and ambition for the local place and to build a consensus on local priorities.
- To help local partnerships withstand the pressures and pace of change, many local places are investing in development programmes to strengthen relationships and expand leadership capacity. Learning is focused on developing behaviours that build trust, enable collaboration and manage conflict.
- Effective place-based leaders are moving their thinking beyond the integration of health and social care to develop a shared understanding of their combined resources and assets, and then are using this as the basis for joint action.
- As they implement their long-term plans, local leaders are managing simultaneously to balance the needs of the whole population with the aim of delivering better care to individuals. They are using a combination of techniques for joint commissioning, applying population health management and asset-based approaches.

- Good governance is undoubtedly fundamental to place-based working. Places that are more rapidly progressing their plans are avoiding becoming distracted by rigid, bureaucratic and top-down governance structures. Agreements such as Memorandum of Understanding between partners have set the parameters for partnership working, enabling partners to get on with the job of working jointly. In many instances, health and wellbeing boards are providing an effective local structure for governance and accountability.
- Although early days, local partners are learning to accept responsibility for the overall financial position of the place. Different approaches to contracting are being used to move away from the perverse incentives of a tariff-based payment system. For instance, they are introducing contracts that blend a fixed amount with incentives to manage growth in demand and activity levels. To facilitate financial management of the place, leaders are applying open-book accounting, sharing provider data and developing a single approach to business case development. Most important, financial leaders report working in tandem with operational leads for oversight and problem-solving.
- Local places are involving local citizens and communities in different ways in the governance and decision making, but all consider this involvement integral to the delivery of local plans. Prioritising the involvement of people with lived experience is considered especially good practice. Working with community leaders and anchor institutions offers the scope for innovation and drawing on wider community assets.
- Having a core group of highly skilled and experienced staff to support the local partnership enables place-based working and the delivery of the local ambition. With their teams and a dedicated resource, they provide the capacity for project management, governance support and financial monitoring.

Introduction

Integrated care systems (ICSs) face a number of competing pressures, needing to reach financial stability and control demand while simultaneously improving health, care and wellbeing.

Each system leader has now developed an ambitious and detailed plan to meet this broad transformation agenda. Yet these plans depend on an array of complex partnerships, structural reforms and behaviour changes, with leaders recognising the limits of what they can achieve on their own, especially at system level. Faced with this degree of complexity, system leaders are focusing much of their energy and resources on coordinating actions at the local level, using place-based approaches.

This level of working offers the right scale and scope for tackling population health challenges – from health inequalities to the wider determinants of health – and for maximising opportunities across all public services through integration, service changes and aligned resources.

In practice, this requires close working arrangements with local authorities and other partners, such as housing associations and the voluntary sector. It also requires unwinding competitive behaviours between local providers and reducing the fragmentation of services that leads to people's poor experiences and outcomes of care. With a focus on shared priorities, this shifts partners' conversations to how joint efforts will benefit local people.

There is growing recognition among national organisations and senior leaders about the importance of place-based approaches:

“[It] is not just about health services, which we all now accept contribute about 20 per cent to overall health. It will mean a very different approach to public health and prevention, and a realisation that improving the health of populations requires action across the public services.”

Niall Dickson, Chief Executive, NHS Confederation

“Taking shared responsibility for population health means the NHS, local government and voluntary sectors working together as partners to make the best possible use of their reach, resources and assets to innovate and tackle the causes of ill health.”

Paul Burstow, Chair, Hertfordshire and West Essex Sustainability and Transformation Partnership

“Our ambition is that the overall plan for each place feels like it is the people’s plan for the place – their plan. To enable this, we make sure that within our governance structure we have the public and third sector and NHS and council involved at the highest level.”

Rob Webster, ICS Lead, West Yorkshire and Harrogate Health and Care Partnership

This paper describes the essential role of place-based approaches in taking forward the NHS reform agenda. It seeks to provide further insight into how local systems can make progress in designing and delivering place-based, integrated care – and especially describes what system leaders can do to make this happen.

Combining insights from interviews with system leaders, policy papers and other literature, the paper highlights early learning as well as emerging good practice in place-based working.

Illustrative examples from integrated care systems and sustainability and transformation partnerships (STPs) cover different geographies and populations, but there are common themes about what to prioritise and how to take practical steps forward.

The paper looks at specific lessons for systems leaders in the following areas:

- setting the ambition and guiding principles for place-based approaches
- investing in collaborative leadership, especially with local government
- designing the right system governance that strengthens local partnerships and shapes an environment supportive of collaborative working

- prioritising and responding to the needs of local people, while applying population health management techniques and asset-based approaches
- balancing the need for strong system financial management with local decision making to align incentives and outcomes frameworks, reward outcomes and control activities
- engaging and co-producing plans with local citizens.

What do we mean by place?

We use the term 'place' flexibly because of the variability observed in local arrangements. No single 'one size fits all' approach to defining place exists: each place reflects a unique geography and relationship to local people and communities.

The NHS has defined 'place' as meaning geographies comprising populations of 250,000 to 500,000. In many areas, there are existing geographies at the scale of upper and lower-tier local authorities that already have a significant degree of coherence, including effective governance structures.

As described in *Shifting the Centre of Gravity: Making Place-Based, Person-Centred Care A Reality*, the boundaries of the local place should be determined "following local discussion and considering the role of all the partners who contribute to health and care in a place" (Local Government Association et al., 2018).

Local places also build naturally on previous efforts to integrate care and local services, such as the Better Care Fund and integrated care pioneers. Strategic leadership at the place level also supports the development of primary care networks and integrated care providers.

Setting the ambition and guiding principles

Co-producing a compelling vision

The system leaders we interviewed consistently stressed the importance of getting the vision right for place-based working. Recognising their shared priorities and the scope for joint action, they cited a set of common themes for integration at the place level:

- improving health and wellbeing for the whole population
- delivering better care for individuals, especially in the community
- improving their experiences of care.

They report using asset-based approaches to harness the full range of resources and opportunities available to the individual and the community, moving beyond health and social care services. Combined, this is a broad agenda that extends beyond the boundaries of health and care services.

Getting the local vision right, however, is more than a top-down translation of the ICS or STP plan to the local place. Instead, the process of setting the ambition locally is as important, if not more so. Because a local partnership will deliver the vision, the process requires genuine co-production with a broad range of local stakeholders acting as a 'coalition of the willing'. This will involve politicians and officers from local government, and leaders and representatives from public health, housing services and the voluntary and community sector. Leaders suggest that out of this broad coalition, collaborative and creative solutions to local challenges can arise.

For instance, the West Yorkshire and Harrogate Health and Care Partnership has a well-developed vision for place-based, integrated care addressing the wider determinants of health. Each of the six local places that make up the ICS has developed a unique partnership and their own local plan for delivering place-based care and tackling the wider determinants of health. Local authorities are prominent in each partnership, and each area is moving towards a single commissioning arrangement between clinical commissioning groups (CCGs) and local councils, to ensure a stronger focus on local places and engagement.

However, there is recognition that the place focus has only thrived as well as it has because strategic leaders at the ICS level grasp its importance, and are signed up to clear principles of how the system should operate at each level – the system level (ICS), the local place level and in neighbourhoods.

Most important, the local vision should include a clear articulation of the benefits for local people. Usually, the starting point for engaging local government leaders is asking, “what are the health and care needs of our local population?” and “what matters to local people?” Asking these types of questions better aligns the concerns of local councillors with NHS leaders and keeps them engaged on shared priorities. Similarly, these questions might form the starting point for building primary care networks and engaging with local GPs.

“Achieving ICS status is not an end in itself. What matters is whether we make a difference to the health and quality of life of the populations we serve. Taking shared responsibility for population health is the most important shift our partnership must make in 2020.”

STP Chair

The process of developing a local vision necessarily incorporates contextual factors, such as specific population health challenges, available resources, local provider capacity and workforce capability. Importantly, we were told that the vision needs to be honest – setting out what can be realistically influenced and achieved, but also at what cost and what may need to be stopped to make it happen. Where trade-offs are required, these should be presented transparently. Moreover, accessible language should be used to explain how the local vision relates to the specific place and how it will benefit local people.

“A Better You is the approach we have developed – a brand almost – in response to how important self-care was to us and people in the borough. There is often a focus on services that are for the treatment of diseases, but we felt it was important to make a shift to empower and equip people to live better lifestyles and to better self-care. The three principles of A Better You are: 1) being proactive, 2) being fair (equitable – inequalities are a massive issue for us, so we know more time and energy and money will have to be spent on neighbourhoods that are most deprived, and this is an important part of our work) and 3) person-centred. That kick starts a different conversation.”

CCG Chief Executive

Agreeing guiding principles

Those we spoke to emphasised the importance of system leaders developing clear guiding principles to govern place-based working across the partnership. These principles must be discussed openly and through dialogue to test whether people have the same understanding. It can be beneficial to capture these principles formally so that they can be shared and referred back to, such as a partnership framework or Memorandum of Understanding, which all partners sign and agree to uphold.

In Bradford, for example, local commissioners and providers have signed a Strategic Partnering Agreement (SPA) which sets out the framework for roles, responsibilities, leadership and decision making in their local place or integrated care partnership. Holding partners to agreed principles and ways of working can be difficult, but spending the time to create and agree the principles is advantageous and ultimately facilitates progress.

What are the most critical guiding principles?

1. Subsidiarity

Adopting a set of criteria for what happens where (at system, place or neighbourhood level) will facilitate governance and decision making, especially for place-based working. Those we interviewed stressed the primacy of the place over the ICS, as well as the facilitative role of the place in supporting primary care networks and collaboration at the neighbourhood level.

In practice, this means system-level leaders should mainly play an enabling and supportive role, concentrating on the overall sustainability of the health and care system, and supporting the delivery of tertiary services. West Yorkshire and Harrogate Health and Care Partnership, for example, has formalised this through a subsidiarity test which has been adopted in all six health and wellbeing board areas.

2. Transparency

A consistent theme raised by stakeholders is the need for leaders to be transparent, being open in all their interactions with other stakeholders. Greater transparency leads to trust within the local partnership. In the area of finance, this might be about adopting open-book accounting with partners. In wider partnership working, it is often about being upfront early in any process, about the key issues and challenges.

“Honesty about things and transparency: everyone has to have an inkling about what is going on. When you are working in a hierarchy, you put forward the best option of the truth. But what we do, because commissioners and providers are sharing information all the time, we say we carry this amount of risk. We have the information and we have conversations about how we can manage that risk collectively, rather than having to fudge.”

ICS Lead

3. Distributed leadership

Combined with the principle of subsidiarity, distributing leadership to the place and neighbourhood/locality creates the capacity, momentum and enthusiasm to transform services. System leaders, who are trying to forge place-based ways of working, should be mindful of their relative power, and avoid the temptation to intervene in the decision making within local areas.

System leaders should play an enabling role, rather than a directive one, by demonstrating collaborative behaviours themselves, supporting leadership decisions at the place level and avoiding heavy-handed or prescriptive governance.

“Within the ICS, all the key roles are taken up by people who work within all the different partners of the system (such as from community organisations, the NHS, local authority and so on) – which leads to shared ownership and accountability. Distributed leadership is really important for this collaborative approach.”

ICS Board Member

4. Outcome focus

System leaders in place are urged to maintain a constant focus on outcomes, on the question of what matters to local people. This requires leaders to agree what the defining outcomes are for the local population, and to be held accountable for achieving them. This requires clarity about how performance will be judged: on the achievement of population outcomes rather than those for individual organisations.

“We have a set of outcomes measures, they are broader than the usual measures, such as emergency admissions. They focus on child health, life expectation and quality of life. We constantly refer back to them when we are together as place leaders.”

ICS Lead

Strengthening local partnerships

Place-based partnerships typically fit into a recognisable geography, one to which the public can easily relate. This is unlike the boundaries of an ICS or STP, in which health and local government are typically not coterminous and where the footprint is not understood meaningfully by local people. Consequently, we found place defined differently in different places.

Prominent local authority involvement was a consistent characteristic of the place-based partnerships we reviewed. Our findings echo those of the King's Fund, which observes that "the 'place' may be defined by a local authority, clinical commissioning group or acute trust footprint, or determined by the natural geography of a town" (Anna Charles, Lillie Wenzel, Matthew Kershaw, Chris Ham, and Nicola Walsh, 2018).

"How the NHS is defining place is not what local people would recognise as place. For example, the NHS considers a place of around 250,000-500,000 people. Instead, [we] are focusing on the footprints around the acute hospitals and the evolution of PCNs. This means greater involvement of CCGs and local authorities."

STP Lead

System leaders were "considering the role of all the partners who contribute to health and care in a place," and taking steps to strengthen partnerships built on the foundation stones of previous joint working. Where there is a history of commissioners and providers collaborating, they felt there was no need to redesign or superimpose new partnerships. Rather, local places should build naturally on previous efforts to integrate care and local services, such as the Better Care Fund and integrated care pioneers. Taking this approach acknowledges the essential element of time in building partnerships.

“[Our local authority] can convene countywide meetings, including public health and health colleagues. It provides a political mandate, including 11 local MPs, and it is the level at which many integration projects are organised. It also covers a lot of estate and planning functions. It has to have a powerful voice.”

STP Board Member

“It’s a partnership, it’s a true partnership, which means we have worked incredibly hard over the last three-and-half years to make everyone feel like an equal partner. Councils, NHS partners, communities and all should feel like they have a say.”

ICS Board Member

Place-based governance: a central role for local government

Leaders spoke about the importance of having a governance structure at place level to deliver the system integration plans. Their approaches to system architecture and governance were variable: there was no 'one size fits all' approach, with governance essentially emergent. Some leaders shared the view that an over-emphasis on standardising governance structures and process could hamper local creativity and the organic evolution of arrangements best tailored to local requirements.

Leaders stressed two key points:

1. Place-based governance arrangements are building on existing partnerships because of prior relationships and successful joint working.
2. Local government is at the heart of place-based working because it clearly defines what is the place and has an existing structure for accountability.

For these leaders, good governance is not seen as the end goal but as an enabler of stronger local partnerships.

The majority of place-based partnerships have built on existing partnerships and operate at the level of the local authority, with alignment to health and wellbeing board (HWB) footprints. In Nottinghamshire, for example, underpinning their place-based approach is a strong commitment to the principles of equal partnership, especially between the local authorities and the

NHS, building on the history of working together.

In several of the local areas, HWBs provide a highly effective existing governance structure and vehicle for place-based working. Partners have a forum for agreeing priorities, navigating and resolving tensions, and helping to keep attention focused on the bigger prizes: improved health and wellbeing outcomes for communities.

“We have tried to be pragmatic, not revolutionary, on structure. We go where the relationships are strong.”

STP Board Member

Leaders acknowledged that governance of place is challenging because it depends on the strength of partnership relationships. Competing financial pressures and timescales can interfere with these relationships because they affect both the transparency and pace of decision making.

Shaping the environment

Participants in this research consistently emphasised the importance of nurturing trusting relationships for place-based working and reported playing a crucial and active role in shaping a trusting environment. They also mentioned valuing the time it takes to build trust. Leaders spoke about helping to manage relationships at both the system and place levels, tackling disagreements and conflict, and addressing underlying power struggles and cultural differences, “like a branch of Relate,” mentioned one leader.

Several others commented on the importance of modelling effective leadership behaviours at the system level, which in turn encourages effective leadership in the level or place.

“The leaders at the ICS level often double up as leaders at the place level – if we don’t show a willingness to listen and build bridges at system level, it won’t encourage good behaviours at the place level.”

ICS Lead

Leaders are in a position to both demonstrate and encourage effective partnership behaviours at the level of place, especially influencing and persuading colleagues “with head and heart”. This is done by making use of data and good evidence, as well as using stories and compelling narratives to motivate partners and their actions.

Other leadership actions mentioned by system leaders included:

- taking the time to develop and agree a shared analysis of the problems partners are tackling
- operating on the principle of 'doing the work once' and reducing duplication
- creating a forum to share good practice and work together on wicked issues.

For trust to be developed and maintained, we also heard that leaders must be willing to step into another person's shoes – to show empathy about the challenges and constraints others face, but also to learn about other ways to solve problems.

“Maintaining and developing effective working relationships is a bit like painting the Forth Railway Bridge: it is never ending. Leaders must be able to see things as others see them, to be able to walk in each other's shoes.”

STP Chair

“At a recent event, I asked GPs to present to the acute ‘a day in the life of’ and explain what they do, how they are paid, and it was fascinating. Then I asked hospital consultants to do the same. I think the exercise helped both parties to understand that some of their practices were undermining the system.”

ICS Board Member

Another important role for system leaders is eliminating some of the barriers to effective place-based working, especially ones related to system governance and leadership behaviours. Some leaders commented on the persistence of competing performance and regulatory frameworks, which can interfere with collaboration and encourage bad behaviours on the part of individual organisations. The leaders spoke of their concern that a top-down regulatory style may be imposed on ICSs that would interfere with fledgling – and in some cases delicate – local partnership arrangements at both system and place levels.

“Central control is like a tsunami. It’s as if we are at the shore as the water is retreating. The force is dragging us out, and we can’t swim away from it. We are at risk of being washed up on the beach. We are unable to stop the tide.”

STP Leader

Although unresolved, we heard about how system leaders in at least one ICS are taking a stand and are pushing back against the national regulator’s performance regime in order to support its place-based partnerships.

Creating a workforce committed to place

Developing leadership capabilities

Those we interviewed were clear that good place-based leadership skills do not necessarily come naturally to NHS leaders or, for that matter, to local government leaders. New kinds of organisational and leadership development approaches are required, informed by the latest thinking on systems leadership and place-based working.

Leadership programmes will need to become more inclusive of non-NHS and community leaders, and have a strong focus on collaborative and distributed leadership models. One ICS leader described how a previous investment in local clinical leadership, such as GPs, was already making a difference to integration. They are sustaining and expanding this investment with a cross-sector 'whole system' leadership development programme, with participants collaborating on problem-solving and designing place-based solutions.

“You need to involve a wide range of people in leadership development. Together, we have invested in the Surrey 500 initiative, which reaches across all sectors. Working at place footprint, this is a global system leadership programme that builds relationships for the future. As part of this, participants tackle system challenges together, such as loneliness.”

ICS Lead

Skilled and experienced staff supporting place

In a recent paper for ICS leaders, the NHS Confederation describes the importance of having an ‘engine room’ to drive the work of the ICS – that is, a team of staff who sit below the executive leadership and provide support to drive forward integration and system redesign (Pett, 2020). Research participants told us that having a similar core team of highly skilled and experienced staff at the place level is essential.

These staff have a depth of understanding of place-based relationships and their dynamics, and their project management expertise, capacity and resources are essential for maintaining momentum. By focusing on the place, they play a role in sorting out differences between partners and holding them to account. Their experience of stakeholder engagement and communication is especially important, as is having the knowledge of how the voluntary sector and local politics operate.

“You need people who have worked in several different local roles, such as community development or local government, who understand how to get things done locally.”

ICS Local Government Board Member

Prioritising and responding to the needs of local people

All the system leaders we spoke to agreed that statutory services only partially impact on people's health and wellbeing, with most outcomes dependent on a range of other social and economic factors. Responding to the needs of the local population – or population health management – requires the contribution of a broader and diverse range of local agencies and stakeholders, who know their communities better than statutory services.

Because of their democratic accountability, the leadership of HWBs was seen as adding credibility and legitimacy to bringing partners together. Several leaders also noted that local government and their elected representatives were more responsive and engaged because the focus was on what matters to local people. They worked hard at narratives that describe how the system plan translates into tangible benefits for local people. At Hertfordshire and West Essex STP, for example, leaders developed a plan for 'place-based care in the place people live', underpinned by three strategic enablers:

- moving to a population health model
- focusing on self-management
- preventing ill health in the community.

Many leaders reported how their local places were beginning to embrace population health management. Although early days, they are using data drawn from across partners to find people with deteriorating health who are slipping through the net, but also to influence behaviours and lifestyles which lead to poor health.

Improving population health, with its focus on outcomes that cut across organisational boundaries, is regarded as a helpful objective for getting all the partners signed up to common goals. Concentrating efforts on population health management and population-based measures – such as childhood obesity and life expectancy – has also helped shift the attention of leaders towards population-based and place-based outcomes, away from a mere focus on organisationally specific targets.

“It’s about acknowledging the give and take. If social care invests in prevention then it will bring about reductions in demand for hospitals. If health increases spend on physiotherapists, this reduces demand for domiciliary care which saves social care money.”

STP Board Member

Several of the local leaders described how asset-based, community development approaches were helping them meet their population health objectives, since they draw on a wide range of partners in tackling the causes of ill health. They spoke of looking for and working with the capacity, potential and resources of individuals, families and communities as a crucial dimension of place-based working, and the improvement of population health. At the heart of this vision is a commitment to tackling the wider determinants of health, such as employment, lifestyles and housing, through a close partnership between health and other local agencies, including housing and the voluntary sector.

“We are meeting with housing and leisure providers, district councils, the voluntary sector as well as police and crime commissioners to put addressing the wider determinants of health at the centre of our strategy so together we can make a big difference to the wellbeing of our population.”

STP Leader

“In Calderdale, we are beginning to use bottom-up, strengths-based approaches to address complex local issues, such as placing work advisers in GP practices to address worklessness and promoting Active Calderdale, a Sport England pilot with the Design Council to encourage sport.”

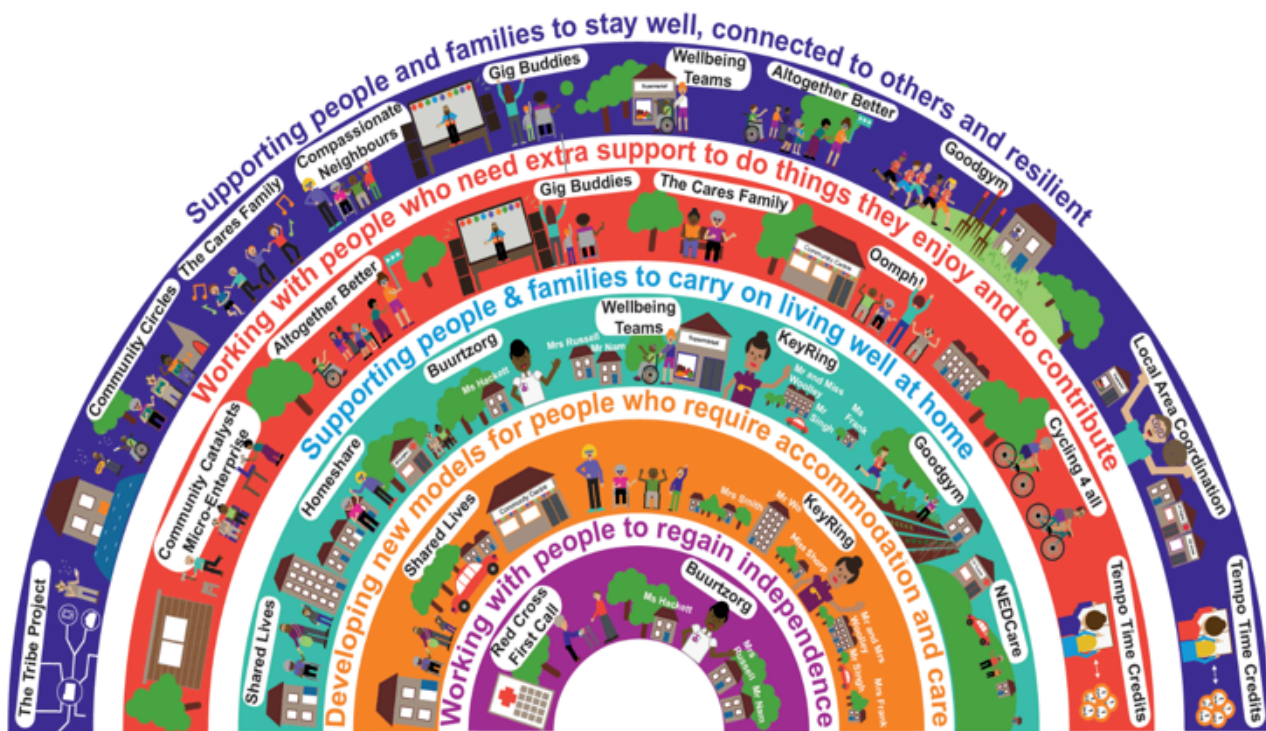
STP Board Member

Areas with well-developed place-based approaches and growing evidence of impact, such as Wigan and Leeds, have a leadership committed to asset-based working. To find and get most value from community assets, health leaders have recognised that they need to share decision-making power, responsibility and resources with community groups and leaders, co-designing local systems and services and investing in community organisations.

For some of those we spoke to, this means re-focusing commissioning on different kinds of providers, those which adopt a person-centred, asset-based approach – connecting people to ways to support better self-care, reduced social isolation and improved lifestyles.

Alex Fox, chief executive of Shared Lives Plus, described the importance of co-commissioning services with the voluntary sector and finding ways to invest in small-scale, but promising, innovations, as depicted ¹:

¹<https://www.thinklocalactpersonal.org.uk/innovations-in-community-centred-support/>



Innovations in community-centred support

There are many community centred approaches out there: this is a tiny selection. More information can be found on the Think Local Act Personal website.



“Health services have never been better at fixing injuries and curing illness, but have never struggled more with helping us to live healthily. To live as well as we are able, we need to maximise our confidence and capacity, our desire for a healthy life, and our meaningful connections with others. None of these are attributes that services can deliver, but they are all things which services can help or hinder, depending on the kind of support relationships they form.”

Alex Fox OBE, Chief Executive, Shared Lives Plus and NHS Assembly Member

We also heard that at place and neighbourhood level, a whole array of collaboration models are emerging, with statutory services engaging with the voluntary sector and key local stakeholders. Leaders spoke about the importance of 'anchor institutions', local enterprises such as universities and hospitals, which are encouraged to take ownership and responsibility for setting the example and leading the whole place system into genuine partnership working.

The ability to plug into the resources and capabilities anchor institutions and the local third sector offer ensures that local place-based working can be ambitious and innovative in the way they plan and design their interventions – and tailor solutions best suited to the local context, both at place and neighbourhood level.

Aligning incentives, reward outcomes and control activities

Robust and joined-up financial systems were seen as vital to successful place-based working. Those we spoke to argued that while the principles for this are becoming clearer – a single place budget, joint commissioning across health and care, and money directed at outcomes rather than activities – we are some distance from achieving success. Leaders reported that their systems were moving away from payment by tariffs towards aligned incentives or fixed-income contracts, which were expected to reduce perverse incentives and balance system risk.

“The current tariff-based model is a monster: you end up with both commissioners and providers spending a lot of time arguing about what has been spent and consumed, and it is driving bad behaviours.”

Chair of an NHS Trust

Most leaders described that their main focus was achieving financial balance by controlling expenditure, activity levels and demand. No one we spoke to had yet found a way to move money around the local system or to invest in prevention and early intervention – even though these were the ambition for the place and the incentive for partnership working. Neither had they found consistent ways to tackle the financial tension between priorities of the place versus those of each provider.

Yet the leaders generally remain optimistic about their place-based working arrangements. They recommended having a group of financial and operational leads, working in tandem as a forum for balancing the demands of system financial performance with the delivery of better care. In **Bradford**, for example, their new Joint Finance and Performance Committee was enabling them to broach difficult financial topics and to sort out solutions that worked for the whole local system.

System leaders were taking important steps to balance the financial needs of local places with the demands from the ICS or STP. These include:

- making sure that finance leaders meet regularly and clearly report into strategic partnership boards – and involve operational leaders in their discussions
- applying open-book accounting and sharing provider data to help create ‘one version of the truth’ of the overall financial position
- confronting disagreement early in planning processes and not avoiding difficult conversations
- exploring the potential of different contracting models, such as fixed-income contracts
- developing a single agreed approach to developing and agreeing business cases for investment
- if possible, co-locating CCG, NHS trust and local authority finance teams – this helps build a greater understanding of each other’s operational environment, collaborative behaviours and joint financial planning.

Engaging and co-producing plans with local citizens

The leaders we interviewed were clear that place-based working will not be a success unless they co-produce their health and care services and improvement plans with local communities. Both formal and informal means of involvement were shared.

They stressed that co-production and engagement can serve to build citizen ownership and support for plans, bring in additional resources, insights and expertise into service design. They also help planners develop plans that will improve experiences and outcomes. Asset-based approaches apply here as well, as they rely on designing care with people, drawing on their skills, networks and capabilities.

Although acknowledging the challenges of representation, the leaders provided numerous examples of how place-based plans and services are being shaped by local people. They also offered innovative examples of where services have been improved as a result of the direct involvement of people with lived experiences. For example, the Hertfordshire and West Essex STP has invested in arrangements to increase the involvement of people with lived experience in service design. The partners have established a strategic co-production group, looking at personalised care.

“As a group, we worked with health, care and social care practitioners to develop and enhance ‘My Plan’, which describes a person’s life and preferences to support personalised care.”

Strategic Co-Production Group Member

Many places are building on a strong track record of engagement with citizens and communities. Local government plays a central role as convenor and bridge builder, and in some instances a source of financial resource. One example is the Camden Health and Care Assembly, a citizens' assembly that uses the principles of deliberative democracy to shape priorities for local communities. The assembly first addressed environmental issues and is now addressing the future of health and social care.

Another example comes from the One Croydon Alliance, which supports engagement across the commissioning cycle and is known for working effectively with the local community and voluntary sector to ensure seldom-heard groups have a voice in setting priorities and designing services.

The examples suggest a number of activities for supporting citizen engagement and co-production. The first set of actions bring the citizen voice into decision making, from involving community leaders on executive boards, to founding a formal co-production forum that involves people with lived experience in planning and service design.

They also described harnessing the capacity and knowledge of local volunteers, for instance as community navigators helping support people to find support. While by its nature asset-based approaches need to be driven by communities, there are steps place-based leaders can take to encourage their development. In Leeds, for example, they have involved over 5,000 staff through a Better Conversation culture change programme, which provides the skills to staff to work with people in a collaborative, asset-based way.

Realising the benefits

Emerging lessons from systems across the country suggest the following good practice for realising the benefits of place-based working. They are presented as a set of practical questions:

Co-producing a compelling vision for place-based working

- ✓ Do local systems leaders, working in partnership with local partners and communities, have a shared definition of the local place?
- ✓ Have all of the main partners in the system, including local authorities, the voluntary and community sector and PCNs, worked together to agree a set of shared priorities for the local population and to develop a narrative for the place?
- ✓ Have people with lived experience been actively involved in developing these priorities and the narrative?

Widely understood and agreed approach to place-based governance

- ✓ Are system leaders clear which decisions are devolved to place level, and where and how they are taken, either through a new place-based board, existing joint commissioning arrangements or health and wellbeing boards?
- ✓ Do local partners have an agreement or a Memorandum of Understanding which defines the ways of working and expected partnership behaviours?

Engaging local government and other partners

- ✓ Are elected members involved throughout the process of developing a narrative and place-based planning?
- ✓ Does the place-based board have representation from elected members, local government, primary care networks, the private sector, voluntary and community sector and housing?

Developing trust and effective behaviours

- ✓ Do system leaders take time to visit other organisations and services to build a better understanding of their operating environment and cultures?
- ✓ Are there mechanisms in place to raise and resolve conflicts openly?

Investing in leadership and delivery capacity and capability

- ✓ Has a common support team been brought together to provide support for place-based governance, local system transformation and financial oversight?
- ✓ Is there a tangible investment in building distributed leadership capacity, such as a programme that involves leaders from across local partner organisations, including the local authority, voluntary and community sector and housing?

Prioritising the needs of communities and drawing on their assets

- ✓ Are system leaders bringing together local providers with a clear commitment to working together to improve population health using population health management approaches?
- ✓ Do system leaders have a shared commitment to using asset-based approaches, which build on the skills, networks and resources of local people?

Balancing system finance management

- ✓ Do all partners have a shared understanding of the available financial resources and local financial pressures?
- ✓ How is joint commissioning informed by population health management and asset-based approaches?
- ✓ Are financial controls enabling the alignment of resources to health and care outcomes?

Engaging and co-producing plans with local citizens

- ✓ How are local citizens and people with lived experience involved in the governance decision making at place level?
- ✓ Have leaders set expectations for co-production arrangements, which ensure that people with lived experience and carers are involved in the design, planning, commissioning and evaluation of local services?

Conclusion

Local place is where the real action is. System leaders can advance their system plans by concentrating on what makes place-based working effective, particularly by giving due attention to the involvement of all aspects of local government, community organisations and leaders.

Place-based working means creating better health and more responsive, joined-up services for a defined area. It requires leaders to be able to think in terms of communities and neighbourhoods that local people would recognise. It means bringing together all the agencies and leaders in an area, including local government and community organisations, recognising that sometimes the NHS will need to be ally and partner, not leader.

The main finding from this research should not come as a surprise to those who have worked in senior leadership roles in health and care systems: it is people, less structures and systems, that have facilitated progress on place-based working. To make place-based working a reality, committed leaders are needed. Leaders who want to build a shared vision and purpose, who are constantly seeking to build good relationships with colleagues in other parts of the system, who are relentlessly focused on outcomes for local people, who are willing to repeatedly take risk, and who give the 'air cover' for others in less senior roles to take risks. Those system leaders doing this well told us it should and often feels very hard. It is the nature of system working where the problems you are trying to solve are often intangible and the solutions unknowable in advance.

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Who to contact – your regional lead

Our regional leads are on hand to support ICSs and STPs across the different regions in England. They provide access to learning and good practice, support relationships and leadership development, and create opportunities to influence national policy and thinking. They also provide a stronger and more direct link between members and the NHS Confederation, acting as a conduit to transmit messages and concerns to national bodies.



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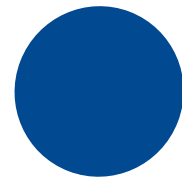
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