Integrated Care Systems Network
NHS Confederation

The state of integration at place

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About us

NHS Confederation

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Integrated Care Systems (ICS) Network

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Key points

- Integration at place is crucial to meet the health and care needs of England's communities. At a time when significant challenges face our public services, most recently detailed in Lord Darzi's investigation of the NHS in England, a focus on the places that matter to people and communities offers a path forward. Bringing together all the organisations that impact a local population's health and wellbeing to work more closely and seamlessly is paramount to achieving this.

- Our research is clear that place is often the spatial level where system integration is best delivered and the biggest gains are possible in tackling inequalities, delivering more proactive, preventative care, delivering a 'community first' health service, and contributing to social and economic development.

- However, a number of factors are currently holding this back in some areas: the challenging financial and operational environment; pursuing integration without a clear, locally determined purpose; and a lack of system or partnership maturity to accelerate this work.

- The current financial environment in both the NHS and local government is not only restricting place integration in some areas but, in many cases, actively undoing it because: 1) a national emphasis on getting a stronger grip on the financial pressures in the NHS has led to command-and-control behaviours trickling down into the system; and 2) the running cost allowance reductions asked of integrated care boards (ICBs) have had a restricting effect on affected place-level teams.

- Many models have been copied from one place to another with the aim that the same success can be achieved, but this fails to gain the organic, bottom-up traction required for success. Time and again we heard that locally identified priorities – with integration being the means rather than the priority itself – were necessary ingredients for successful place integration.

- We saw two models for how place partnerships function as part of systems and in relation to neighbourhoods. On the one hand, we heard leaders describe a 'Russian doll' model whereby neighbourhoods are the most local levels of scale for planning and delivery, sitting within places, and places in turn sitting within systems. On the other, we heard of a 'hub and spoke' model whereby strategy is set at system level, detailed planning and some delivery are progressed at place level, and neighbourhoods are primarily seen as 'delivery vehicles' within place-based partnerships. Neither model was deemed better than the other, and indeed, systems should find the right model for their context.

- To continue to accelerate integration at place, leaders are keen to see:

    — place given more prominence in national policy across Whitehall, in health policy but also more widely

    — a focus on the public pound across a place, rather than what can be siloed, organisational budgets, with aligned, multi-year funding and planning cycles for the NHS and local government, and fewer barriers to pooling budgets and allocating resource according to local need rather than national dictation

    — a greater focus on outcomes, not activity

    — supporting the system to work towards better data sharing, better representation of different parts of the sector, and richer conversations with the public about these changes

    — a move away from a focus on constructs, particularly NHS constructs, and towards community-driven and community-focused delivery.

Foreword

Integration between health and local government is critical to the success of the government's mission to improve the nation's health, devolve greater decision-making, and renew focus on local economic growth, such as through a planned statutory requirement for local growth plans. The dual need to be smarter with the public purse and to offer better, more equitable and more preventative public services means that transformative change is required.

Lord Darzi's investigation into the NHS in England was clear that the work that needs to happen involves the NHS making greater contribution to the nation's prosperity, simplifying care delivery through a neighbourhood NHS, accelerating the shift towards care delivery closer to home, and re-empowering patients to take control of their care. Integration at place, as identified through this report, offers an opportunity to deliver on those ambitions.

Place is often described as the 'engine room' of integration, and for good reason. This is the geographic, spatial level that services are most often organised around, and the level at which local authority, NHS and other services can work together to have the biggest impact. It is often the geographic scale that communities identify with. That said, we draw two clear conclusions from this research. Firstly, that integration at place is most successful when it is driven by local partners coalescing around a specific, local issue (not when the model is imposed upon them); and secondly, that progress must be judged in the context of the operating environment of the moment, which is coloured by pressure on finances and performance in both local government and the NHS. The current climate is hampering progress towards integration at place. The research is clear that this is not just a luxury to be pursued sometime in the future but is crucial to both overcoming the most immediate pressures as well as our long-term aims. Now is the time to accelerate this way of working.

While this publication is primarily intended to support leaders across the sector to learn from what is happening across the country, the research has also led to recommendations for national government. Our view is that for integration to thrive, place must be given more prominence in national policy across Whitehall, accompanied by a focus on the public pound across a place, fewer barriers to pooling budgets, a greater focus on outcomes, better data sharing and a concerted move towards community-driven and community-focused delivery.

Integrated care systems are the right structures to improve health outcomes for local populations, and they are making strides despite the challenges described in this paper. The evolution of place, and in turn neighbourhoods, is a crucial part of this journey, and we look forward to working with colleagues up and down the country to learn and develop together to achieve what is set out in this publication.

Dr Victoria Ellarby, Director of Place Development and Integration (South Cumbria), Lancashire and South Cumbria ICB

Cllr Tim Swift, Deputy Leader, Calderdale Council and Integrated Care Partnership Chair, West Yorkshire ICS

Dr Kathy McLean, Chair, ICS Network and Chair of Nottingham & Nottinghamshire ICB and Derby & Derbyshire ICB

Introduction

With increasing pressure on the health and care sector, there is an urgent need to prioritise community-centred design and delivery of services. This means:

- focusing on those most in need and those who too often do not access the services they need
- addressing long-term population health trends
- keeping people out of hospital where possible
- supporting them closer to their communities
- keeping them healthier for longer, by ramping up proactive and preventative care
- tying peoples' health and wellbeing more closely to local social and economic development.

Achieving this demands a strong central vision and mission-driven approach, as the new government has set out. But it must also empower local leaders to collaborate, innovate and improve.

The potential of this approach is substantial. In one area, for example, adults with learning difficulties are three times more likely to both be in work and to live independently compared to the national average. This is due to integration at place, which has allowed for social models of care to be developed and delivered. This means both better outcomes for people locally, but it also delivered a multi-million-pound cost-saving to the local system. Scaling the integration that led to these improvements nationwide would lead to more sustainable, more accessible services, and a healthier population too.

This report, therefore, details how integration through the places that matter to people can shift the government's ambitions from a set of ambitions into a working reality. It is aimed at national leaders and civil servants seeking to understand their role in fostering true systems working; at local leaders seeking to deliver a step-change in how their local services are delivered and learn from others around the country; and at those in the wider health and care sector seeking to understand what we mean by place and why it matters. It draws on the insights of over 60 leaders across integrated care boards, integrated care partnerships, local NHS services, including acute and primary care, local government and the voluntary, community and social enterprise sector, and two roundtables with local leaders focused specifically on how a new Labour government can best enable integration at place.

The role of place

The formation of integrated care systems (ICSs), with their diverse sizes, demographics, population health challenges and organisational make up, highlighted the need to prioritise local communities in service planning and delivery. To counteract the risk of detachment from local needs due to the larger scale of ICSs, there has been an increased focus on 'place' and 'neighbourhood' as key levels for delivering effective integration. Working at these different scales predates ICSs by several decades, most notably in local government. Much has been, and continues to be, learned from that.

What is 'place'?

Defining 'place' is complex, as it varies in meaning across the health and social care sector. While perhaps challenging, this malleability is crucial. Thriving Places, a guidance document produced by the Local Government Association (LGA) and NHS England, states: "The footprint of place should be based on what is meaningful to local people, has a coherent identity and is where they live their lives – such as a town, city, borough or county." This could mean many things depending on local context – for example, compare the needs of a central London borough to that of a coastal town in the North West, or a sparse, rural population in Gloucestershire.

We have also observed a difference in definition depending on the agency describing it. It may be that a local authority leader defines it differently from a charity leader, and again differently from a local resident. What is set out in this report is how the NHS Confederation is defining place for the purposes of this work. Thriving Places also sets out different governance models that place partnerships can take, including sub-committees, joint committees, lead provider arrangements or more simple arrangements.

Places should align with local service boundaries to streamline operations for providers and partners. Most places correspond to local authority footprints, often serving 250,000-500,000, though some can cover up to 1.2 million people. These partnerships are collectively viewed by health and care leaders as the engine rooms for integration, where a lot of the delivery for integrating care services happens. Indeed, many systems do not use the word 'place' at all. In some areas, they refer to 'alliances', others talk about 'localities', and some simply 'partnerships'. Whatever their labels, they refer to planning and delivery at a more local level that makes most sense for driving the changes local populations expect. These partnerships typically include local government, NHS providers, voluntary, community, faith and social enterprise (VCFSE) organisations, social care providers and others.

Interviews conducted for this report revealed that the structures and operating models for place-based partnerships were largely determined by contextual factors that sit outside of the day-to-day control of local leaders. These include:

- geography
    - Scale
    - Location (urban, coastal, rural etc.)
- population size
- population profile(s)

- constituent organisations and their boundaries, such as:
    - ICS boundaries
    - local government boundaries
- size and function of provider trusts
- local assets, resources and leaders, such as universities, businesses, infrastructure
- available capacity and financial status.

'Neighbourhood' is a level of scale one degree more local than place, covering a smaller population footprint. While many characterise their 'community' as around 7,000-10,000 people, some neighbourhoods can have populations of up to 50,000. Services at this level often align with council wards or primary care network (PCN) footprints. Neighbourhood-level work has been ongoing for many years, particularly within local government, and effective neighbourhood working has been reported for over a decade, significantly predating the publication of the Fuller stocktake report.

Our case studies and interviews reveal that the success of working at place and neighbourhood levels often lies in the unique, context-specific approaches adopted, which can be challenging to define. This report sets out how local leaders are delivering change at these scales and their plans for future improvements. It focuses on the conditions for success and how they can be supported to accelerate their efforts. We hope to provide a snapshot of progress, contribute to existing literature, and to amplify the voice of place and neighbourhood leaders on the future of health and care.

The methodology for this research is set out in Appendix 1.

The primary mission of place-based partnerships

Given variation across the country in how place-based partnerships are developing, it is understandable why leaders describe their missions differently. However, they all focus on improving health or interactions with health and care services. These can broadly be grouped as follows:

- To shift modes of delivery.
- To target specific population groups or population health challenges.
- To change specific services.

Partnerships grouped under 'modes of delivery' focused on taking population health management approaches to tackling health inequalities in the local area and improving access and engagement with health services for underserved groups. Many place leaders highlighted prevention, the need to rethink how money is spent, as well as how the public and workforce think about healthcare services (that is, moving from a reactive model, waiting until people are worried or sick, to a proactive one). Amplified in light of the government's renewed focus on economic growth, recognising health and care services as anchor institutions and leveraging local assets to better the health and economic wellbeing of the population is crucial at place too. One NHS interviewee noted: "we need to be led by and learning from our local authorities in this area, who've been doing this far longer than we have in the health service."

> "Our number-one ambition is to resolve the inverse care law – targeting those people who need services the most but cannot or do not access them."
>
> Place leader

Other leaders focus on specific groups, such as the frail and elderly population, who are often high-intensity users of healthcare services, as well as targeting children and young people. Some interviewees highlighted specific condition areas they are focused on, including hypertension, chronic obstructive pulmonary disease (COPD), asthma, obesity and suicide.

Spotlight: Reducing acute care admissions in York

Prioritising individuals living with frailty, a Frailty Crisis Hub was launched in York, tasked with creating a multi-agency service that could effectively reduce acute care admissions and ambulance callouts for frail patients. Working collaboratively, local GPs, community response services and VCSE organisations designed a comprehensive model of care.

As a result of this integrated approach, the pilot service launched in 2023, successfully reducing the number of frail patients in acute care and decreasing ambulance callouts by over 100 per month. Additionally, adult mental health services were co-designed within the community, with plans for more hubs to provide emergency care options, thereby reducing the need for emergency department visits.

> "Our first priority was supporting our frail and elderly population. The acute provider took on the risk by putting up the money to create a team across the acute, primary care, social care and others, create the capacity and to work in this integrated way. When we saw the drop in non-elective admissions, we knew the audacity had paid off. That was many years ago, and we grew from there..."
>
> Place leader

Lastly, some interviewees focused on specific service or operational changes, such as improved data sharing between local organisations, promoting digital tools such as the NHS app, and supporting neighbourhood working. There were many mentions of place partnerships coalescing around delivering services in communities, closer to peoples' homes.

> "Our single most important development will be advancing and improving our integrated community teams [ie neighbourhood working] across our places – supported by growing our workforce and retaining staff."
>
> ICS leader

Establishing the foundations of local partnerships

While the narrative around place-based partnerships and neighbourhood working feels more recent to some, interviewees noted that much of this is not new. We spoke to some partnerships at place as long as 15 years into their journeys and some just a matter of months. For integrated neighbourhood working, some have been doing this for 20 years, others as little as six months.

We asked interviewees about the impetus for establishing their partnerships, and clear differences emerged separating those self-assessed as on the right trajectory, despite some broader system challenges, from those who said they were struggling in some way. Those seen to be doing well were unanimously driven by a shared, locally identified cause, ranging from specific health challenges, like increasing COVID-19 vaccination rates in population groups less likely to come forward for vaccination, or improving mental health services for children and young people. Others focused on the determinants of health outside the control of health services, such as embedding health into local town centre development. Many also grew out of a shared goal to deliver better quality services for patients in more financially efficient ways.

Those who felt that their partnerships were struggling noted that too many stakeholders viewed integration as the end goal, rather than as a means to an end. In some areas, while integration was collectively agreed to be the right approach, there was no groundwork to identify the right priorities and issues to corral partners into action. Local leaders should constantly be asking the question: “What are we doing better because we are working together?” Without a clear purpose, integration is unlikely to have a meaningful impact through this way of working or bring people and partners with them on the journey. We heard of systems where leaders sought to

lift a successful partnership model from one part of the system and copy it in another. While the intention was to spread best practice, we heard time and again how what works in one area does not necessarily work in another, largely because of the unique contextual factors described in the introduction. For integration at place to succeed, we heard, it must be organic, driven by local appetite for change, and designed in an intentional way to facilitate that change. The government's integration white paper, Joining-Up Care for People, Places and Populations, and its shared outcomes toolkit helpfully sets out how this can be achieved. We should also recognise, however, that local leaders are eager to learn and understand from what is happening up and down the country, and to use those lessons to help inform their local ways of working. Just because the approach needs to be organic it does not mean that the wheel must be reinvented in every place in every system in England. Organisations such us, the NHS Confederation's ICS Network, and the LGA have a crucial role in supporting the system in shared learning.

As Patricia Hewitt stated in her review of integrated care systems, "More mature systems are supporting their place partnerships to drive initiatives and define their own priorities within the guardrails of the mutually agreed strategy of the ICB and ICP: this needs to rapidly become the norm across all ICSs." This still applies today.

When discussing the process of moving from organisational siloes to truly integrated place- and neighbourhood-based ways of working, we heard that partners sought to progress four development processes:

1. Identifying and understanding shared priorities

2. Developing trust and building relationships

3. Planning and resourcing in partnership

4. Implementing an integrated approach to delivery

When progress falters, it is often because one or two processes are addressed while others are neglected. Successful integration requires intentional and sustained development across all four areas. We heard

examples whereby national government or arm's-length bodies provide funding for specific projects, but local partners tie themselves up in pursuing those opportunities without having identified priorities or having developed local relationships to make the resourcing and delivery of those projects feasible.

Regarding trust, interviewees were clear that it is not as simple as doing it once and moving on.

> "Trust between partners is a sliding scale. The maintenance of trust and relationships requires consistent care and attention."
>
> Place leader

When asked about essential ingredients for successful partnerships, interviewees identified familiar themes: building partnerships of equals, distributed leadership, embedding shared accountability across the partnership, promoting a trusting culture, enabling participation among the full diversity of partners, having the right governance, and having clarity of purpose. This mirrors what we heard during research relating to the development of integrated care partnerships (ICPs) at system level. Above all, interviewees reiterated that their partnerships would be much more successful if they had organic, bottom-up appetite for change. They also commented that 'building partnerships of equals' often sounds straightforward, but accounting for a natural feeling of power imbalance between, for example, an acute provider chief executive and a local charity leader, is by no means straightforward. Interviewees felt it requires constant, intentional effort to ensure everyone is truly on an equal footing.

> "When there is strong leadership and mature partnership working in the local area, with clear priorities, there is nothing stopping us from making change happen."
>
> Place leader

> "We cannot deny that working in partnership can have its challenges, but more often than not the benefits outweigh them. Working at place level often has a greater chance for longer-term sustainability within the system."
>
> Charity partner

Given many place-based partnerships, as described by the government's white paper, have been and are being established at a similar time to integrated care systems, interviewees felt that a lot of time had been consumed by governance. The non-statutory nature of place-based partnerships introduces flexibility and ambiguity, leading to varied approaches to governance. While this paper does not dwell on the complex governance issues relating to place-based partnerships, it is valuable to describe the emerging local models.

Most place-based partnerships we spoke to operate as sub-committees of integrated care boards (ICBs). Many accountable place leaders are appointed and employed full-time by the ICB, supported by a small, dedicated team to deliver work and facilitate partner discussions locally. These leaders often come from strong place-based backgrounds, such as former accountable officers in clinical commissioning groups (CCGs) or executive roles in local authorities. Place leaders we interviewed operating in this sort of arrangement felt that it gave them power and voice to speak on behalf of their place at a system level and champion this way of working. Some did also note that at times they felt a degree of conflict between their allegiance and responsibility relating to the place-based partnership and the role stepping into system, or specifically, ICB issues (for example, related to the running cost allowance reduction requiring ICBs to downscale expenditure on staff and capital).

That said, those who felt this way also felt better equipped to fulfil their role as part of the ICB rather than operating "as an island" locally. A handful of interviewees from outside the NHS felt that ICB-employed place leaders were operating in too siloed a way from wider local leadership and sometimes not engaging with the full breadth of local health-related infrastructure and assets that exists in their place.

Other arrangements include the accountable place leader role being fulfilled by a system partner, such as a local authority leader, a local authority executive (such as a director of adult social services, or director of public health), a primary care leader such as a GP, or an acute hospital chief executive or director. In some places, we saw roles jointly funded by one of these agencies and the ICB. For many in this sort of arrangement, the place role is often a role fulfilled in addition to their primary job role, but they felt that this allowed them to bring their knowledge and experience into the integrated partnership model, and it helped to set the tone for behaviours and ways of working among partners. Moreover, they felt that embedding the place-based partnership in and among the expertise, knowledge and assets locally positioned them well to deliver effective and meaningful change and add real value.

Many place leaders were also represented on ICBs and ICPs, but also reported some challenges in making sure the voice of place and local partners was properly heard and considered at system level.

Spotlight: An operating model based on devolution in the Black Country

The Black Country ICS has a clear operating model based on devolution that has been agreed by all system partners; its place-based partnerships are genuinely place led. All four places in the system – Dudley, Sandwell, Walsall and Wolverhampton – have established place partnerships involving local authorities, voluntary sector organisations, as well as those in wider partners including housing, which they have used to identify the key health and care issues to address in their respective places.

Each place has an ICB managing director that oversees the budget and commissioning responsibilities. Simultaneously, the ICB and ICP have identified work that it is appropriate to undertake at a system level, or in some cases at a wider level, working with the West Midlands Combined Authority. This is underpinned by an outcomes framework that supports targeted investment and impact measurement. Informal delegation was introduced with defined responsibilities, with the health and wellbeing

boards directing population health priorities. The ICB and the Place Integrated Commissioning Committee acts as the commissioning vehicles, while the place-based partnerships lead the transformation and strategy for integrating care.

Place-based partnerships and neighbourhoods concentrate on local healthcare delivery, transformation and integration. Having a clear, delegated framework for strategy and service commissioning enables focused transformation of delivery of healthcare services across the system.

Spotlight: Integrated commissioning models through Section 75 in North East Lincolnshire

North East Lincolnshire (NEL) has implemented a Section 75 agreement to pool £144 million of a total £195 million budget, across health and social care managed by a joint committee including the Humber and North Yorkshire ICB, the local authority and the NEL Health and Care Partnership team. By pooling resources and aligning strategies between the ICB and the local authority, the partnership is creating a more streamlined and integrated approach to service delivery. Currently, the primary focus is on adult services, with plans to extend into children's services and public health initiatives.

The Section 75 agreement has delivered multiple operational benefits. For providers, a single contract reduces administrative burden, supports financial planning, and enhances strategic collaboration. Staff recruitment and retention has also seen improvement due to clearer, more consistent service arrangements. This reduced management burden has enabled providers to place more focus on delivering consistent care, while patients benefit from reduced handoffs between services, improved continuity of care, and better information sharing.

Local leaders described two distinct models of how places operate within systems and interact with neighbourhoods. On the one hand, we heard leaders describe a "Russian doll" model, where neighbourhoods are the most local levels of scale for planning and delivery, sitting within places as a level of scale for planning and delivery at a larger geography, and places in turn sitting within systems as one geographic scale greater. Each performs a similar function at each spatial level, but what they each do is decided according to what makes most sense for the public, for patients and for service delivery. For example, one might argue that workforce planning is best done at system level for a macro perspective, while understanding the needs of disengaged population groups could be better handled at neighbourhood or place where that knowledge is likely to be richer.

Alternatively, others described a "hub and spoke" model where the strategic direction is set at system level (via ICPs and ICBs, integrated care strategies and joint forward plans), with detailed planning and some delivery occurring at place level. Neighbourhoods are primarily seen as "delivery vehicles" within place-based partnerships. Some interviewees identified duplication in what can be done through place-based partnerships and health and wellbeing boards, while in other systems they were seen to serve different purposes. Health and wellbeing boards have a crucial role in delivering joint strategic needs assessments (JNSAs), which are useful vehicles for local data at place level to inform system-level strategy and overseeing pooled Better Care Fund arrangements.

Interactions between these spatial levels are often described in terms of enablement as well as being about decision-making. Regarding enablement, systems are seen as the vehicles for creating the right environment to enable local decision-making at place, while place also works to facilitate, streamline and improve decision-making at system level. Equally, this means creating the right conditions for local leaders to escalate decisions to system level where necessary, not just devolving locally. In the words of Patricia Hewitt in her review: "Rather than thinking about national organisations, regions, systems, places and neighbourhoods as a hierarchy, we should view each other as real partners with complementary and interdependent roles and work accordingly."

In the NHS Confederation's report Prevention, Population Health and Prosperity: A New Era in Devolution, we explore the wider devolution trend in local government and its impact on health and social care. That work highlighted the critical role of place-based partnerships in delivering the government's ambitions on this.

Spotlight: Joining-up care for the people of Oldham

The ten place-based partnership committees in Greater Manchester are pivotal to the GM Integrated Care System. These committees are tasked with facilitating and promoting integrated working to improve population health by shifting services towards prevention and by proactively addressing people's needs promptly and effectively. They emphasise the experience of care, focusing on aspects that matter most to people, carers and families.

In Oldham, this integrated approach involves clinicians, politicians, professional managers and community leaders collaborating to prioritise health creation, prevention and reducing health inequalities. Their collaborative efforts are formalised through an accountability agreement between all partners in the place and Greater Manchester ICB, including how Oldham connects the whole system on innovation, discovery and knowledge sharing. They also have a clearly articulated relationship with their local health and wellbeing board, ensuring a cohesive strategy for improving population health.

Not all neighbourhood approaches were embedded in or supported by place-based partnerships or system-level infrastructure. Some interviewees felt this autonomy allowed them to move at pace and focus on delivery. They emphasised that while the relationships between spatial levels are crucial for aligning priorities and achieving real change, one of the biggest risks was over-bureaucratising these relationships in a way that hinders progress. The freedom to plan and act autonomously at each level was seen as important, and that in one interviewees' words, "not every initiative and programme

at neighbourhood level needs to go through a place committee, and not every place-based initiative and programme needs to go through a system committee".

> "The ICB should focus on the four or five most critical objectives for the system, maintain focus on inequalities between places and seeking to use scale to reduce variation in outcomes. The ICB should be enabling places in delivery and facilitating learning across places."
>
> Place leader

Practically, many place-based teams shared office space, or co-located, with partners. This was most common between local authority and NHS teams, but also included examples like using university campus space. Such arrangements were seen as a real driver for creating "one team" approaches, regardless of the organisations that people were employed by.

From setup to delivery

When asking interviewees how their place-based partnerships and integrated neighbourhood models were delivering meaningful change for their populations, we received numerous examples and case studies of excellent initiatives and programmes being delivered through these channels. These successes often occurred despite wider system challenges and pressures, and they frequently made a significant impact with relatively little investment.

The case studies and examples illustrate two key insights into effective integrated delivery at place. Firstly, they demonstrate how local leadership at place is taking a 'split-screen thinking' approach, addressing immediate pressures while pursuing long-term ambitions that will fundamentally change ways of working and patient and public experiences of health and healthcare services. Secondly, they highlight how collaboration at all levels makes place-based ambitions more tangible and less ad-hoc.

Tackling the most immediate pressures

Many of the practical examples demonstrated how place-based partnerships address urgent health needs, such as collaboration on urgent and emergency care, elective waiting list backlogs, and GP waiting times.

Spotlight: Transforming intermediate care in Leeds

Leeds has established a multi-agency HomeFirst programme delivering better support for people who access intermediate care services. Working as a partnership with Leeds City Council, Leeds Community Healthcare NHS Trust, primary care and the GP federation, Leeds Teaching Hospitals NHS Trust, Leeds and York Partnership Foundation

Trust, and the VCFSE sector, HomeFirst aims to enable a sustainable, person-centred, home-first model of intermediate care across the city that is joined up and promotes independence.

During winter 2023/24, this programme saw significant progress in achieving its aims. While winter is traditionally the busiest period for health and care services, Leeds saw 934 fewer adults admitted to hospital, a reduction of 4.4 days on the average stay in short-term beds, and 351 more people being able to return to their homes safely sooner.

Working towards long-term ambitions

Local leaders who were most passionate about their progress saw significant opportunities in shifting care closer to home, proactive and anticipatory care, prevention, tackling inequalities, and addressing the wider determinants of health and social and economic development. While much of their focus was on translating ambition into delivery, they recognised that they were only scratching the surface of what is possible.

Spotlight: Offering local diagnostic services in Tendring and Clacton

Partners in Tendring and Clacton wanted to make diagnostic services more accessible to the local population by preventing the need for people to travel to the larger hospital in Colchester. Tendring District Council, NHS trusts and wider community partners jointly submitted a bid for the creation of Clacton Diagnostics Centre in partnership.

This pilot rehabilitated existing space within Clacton and District Hospital, and since its opening in 2022 has seen 280,000 procedures undertaken, as well as providing a 24-hour drive-thru facility for health checks and lung function tests. This enables residents to access early intervention support and has also created 100 new jobs. The successful launch of the diagnostics centre has led to funding being granted for the development

of the urgent treatment centre, allowing more people to be supported and treated within the community, instead of having to travel further to a big hospital.

Spotlight: Connecting health and local government services to address housing-related health risks in Hinckley and Bosworth

In Hinckley and Bosworth, the Housing and Respiratory Illness Project focuses on reducing damp and mould in homes to improve outcomes for residents living in affected conditions. The initial phase of this project has established a centralised system for reporting damp and mould concerns identified by professionals, such as NHS clinicians and social services.

These pilots are connected to the County Wide Lightbulb housing service, funded through the Better Care Fund and local councils, which offers comprehensive support including aids and adaptations, energy advice, home safety, and support with hospital transitions. The Lightbulb service, along with its hospital enablement team, plays a crucial role in addressing housing barriers to successful hospital discharge, reducing readmission rates, and promoting overall wellbeing. It has also bolstered local government capacity while limiting demand for NHS services.

Not all examples relate to specific pathway or service issues. The hosting of collaborative, public events has proven a successful model for local areas to change the dialogue about key issues for health and care providers with their populations.

Spotlight: Creating new ways for local populations to understand and engage with health services in York

In 2023, York hosted its first Health Mela, an event dedicated to fostering health and wellbeing in the community, particularly focusing on marginalised groups, including minoritised ethnic communities. The entire partnership contributed to organising the event, creating a vibrant celebration of health and wellbeing. The event was designed to showcase the range of health and wellbeing services in York, emphasising the importance of accessible care during challenging times when services are under pressure.

The event included displays of music and dance performances, along with a variety of stalls offering traditional foods. The Mela appealed to all ages and backgrounds, with over 3,000 attendees enjoying the event in a relaxed and inclusive atmosphere. The success of the 2023 York Health Mela has paved the way for its return in 2025. The Mela significantly increased awareness of local health services available in York, with 92 per cent of respondents to a feedback survey indicating that they now know more about the services available to them since attending the Mela.

When discussing progress towards delivery and impact for local populations, interviewees recognised that many of their projects were either in progress or in development, and the opportunity to see outcomes and impact had not always come yet. They felt that seeing and demonstrating this impact in more comprehensive ways would be a crucial step to accelerating this way of working.

The future of integration at place

While great work is happening locally, often despite some of the wider financial and operating challenges in both health and local government, interviewees set out very clear visions for where they want to be in three to five years, and what is required to help them get there.

When asked about the future vision for their place-based partnerships, some interviewees envisioned a future where place-based partnerships operate fundamentally differently, shifting from NHS-centric constructs to community-driven and community-focused delivery. This means seeing all partners genuinely working as one team rather than as a collection of sovereign organisations, with mutual responsibility for delivery. Additionally, they sought greater co-design of services with people, communities, and a broader range of partners, particularly the VCFSE sector.

Spotlight: Changing the relationship with the local population to address poverty in South Cumbria

In South Cumbria, two Poverty Truth Commissions have been established in areas facing significant deprivation, with the goal of understanding and addressing the needs and aspirations of residents living in poverty. The task of these commissions is to foster dialogue between those in positions of power and individuals with lived experience of poverty. Over a six-week period, four working groups have brought together key figures from the police force, mental health trusts and local councils. An upcoming autumn meeting will involve three newly elected local MPs.

By directly engaging with the community, the commissions aim to develop interventions informed by those most affected by economic hardship. Their mission is to ensure that the voices of individuals with lived experience of poverty are consistently included in policymaking processes, making it a routine practice for these voices to be heard.

Interviewees sought greater progress towards distributed leadership models at system level, with place partnerships driving integration. Related to this was an ambition to see strong local leadership with the autonomy to take risks, recognising that this scale and type of change requires some necessary disruption. There was also a push for recurrent delegated budgets for place-based partnerships, pooled across NHS and local government to jointly commission services via Section 75 agreements. While many recognised that this is a goal for a multi-year development plan, greater use of Better Care Fund and Section 75 arrangements would help make progress towards better sustainability of the public pound. The government could facilitate this by simplifying and broadening these arrangements, reducing reporting and governance requirements.

Along similar lines, many interviewees wanted to shift the focus of place-based work over the next three to five years from addressing immediate pressures to proactive care, anticipatory care, and prevention, with more care being delivered in communities. Many interviewees used the phrase 'community first' and 'enabled' to describe what they are working towards.

Spotlight: Partnership working to deliver wellbeing hubs for children and young people in Tendring

Tendring District Council, Tendring schools, the NHS, the University of Essex, and other partners have together introduced wellbeing hubs in 33 primary schools to help remove barriers to learning by, for example, developing children's resilience and self-esteem, and dealing with anxiety. The NHS Child and Adolescent Mental Health Service supported the pilot during its early stages, Virgin Healthcare delivered a nutrition session for parents, Interact provided youth Mental Health First Aider training, and the University of Essex provided project evaluation.

These hubs operate as an after-school club where children are provided with additional structured support, the parents are supported on issues such as sleep schedules, nutrition, and developing resilience to help contribute to improved attainment levels at key stages 1 and 2.

By engaging with students and parents, positive qualitative outcomes have been documented, including feeling more resilient, equipped and empowered. There is also enhanced participation in after-school clubs, with video testimonials from children and parents about the benefits of the scheme.

Spotlight: Using local partners to respond to recruitment challenges in Mansfield and Ashfield

The recruitment challenge in frontline nursing, paramedic roles and other healthcare roles is widely acknowledged at both a national and local level. Mansfield and Ashfield reported significant skills gaps, with NHS Digital data showing that Sherwood Forest Hospitals NHS Foundation Trust advertised over 300 nursing and midwifery jobs from July 2018 to June 2019.

In response to this Nottingham Trent University Mansfield, in partnership with local healthcare providers, established the multi-million-pound Teaching and Learning Centre in 2020 to offer a range of healthcare courses. The first Nursing students graduated in Summer 2024, with many securing employment immediately. Amy Stevens, a BSc Adult Nursing graduate, secured a role as a community rapid response nurse with Derbyshire Community Healthcare Services Trust and is planning to advance her studies towards becoming an advanced clinical practitioner.

> "The course facilities on campus are beyond expectation. There is a separate unit for those studying nursing and paramedic science and it is evident that the university has really invested in this area, it is fantastic! I like the way the course is designed by combining theory and practice in a coordinated format that is manageable."

Furthermore, the trust, Nottingham Trent University (NTU) and West Nottinghamshire College organised the 'Step into the NHS' event in early 2023 and 2024 to highlight various NHS roles and encourage local career exploration. The event, which drew over 500 attendees, featured

showcases and tours of the Teaching and Learning Centre. It successfully inspired many to consider NHS careers, with on-the-spot interviews for temporary positions and positive feedback from participants.

> "Over time, it should transition away from focusing on the typical NHS issues that currently dominate, and towards the wider determinants of health, and social and economic regeneration and development for our local area."
>
> Place leader

Many interviewees wanted to centre population health management approaches at the heart of their place-based partnerships, aiming to support populations that typically engage with health services only if their needs are urgent or life-threatening – seeking to correct imbalances in access and outcomes. For example, one leader envisioned a population health dashboard for each neighbourhood within their place, with key data relating to priority areas, and for that to be co-produced with residents. Another cited their aim to focus on providing more holistic support in the community to reduce demands on general practice. Interviewees described an intersection here with system working. At system level, there is the bird's-eye view to understand where inequalities exist across the whole geography, including across places, and system stakeholders can work closely with place leaders and teams to address those inequalities.

Interviewees expressed a desire to maintain a sustainable governance structure and workforce at place. They wanted staff to find their work both meaningful and impactful, as well as manageable, and hoped to see the benefits of a "grow our own" strategy, with a pipeline of talent committed to health and social care in the community. They were eager to see how successful initiatives in this area could be scaled up and shared nationally.

Spotlight: Establishing the foundations of a 'grow our own' workforce programme in Walsall

Together, in partnership with Walsall Housing Group, the Department for Work and Pensions (DWP), Walsall College and Walsall Healthcare NHS Trust, the Walsall Together Partnership launched the Work4Health Programme. This three-week employability programme provides participants with CV, application and interview support, along with insights into working in the NHS. Around 160 residents have secured jobs through the programme which, due to its success, is now being implemented in three other areas within the Black Country ICB.

The Black Country system also secured WorkWell funding and became one of the 15 national vanguards working with the DWP, led locally by the Black Country Healthcare NHS Foundation Trust. This initiative highlighted the effectiveness of integration in supporting the local population through addressing employment challenges.

With the evolution of integrated working at place, there is greater opportunity for impact through neighbourhood working. Interviewees felt that once working at place was developed to a sufficient standard, it would become clearer what can and should be delivered at place, but also what might be better delivered at neighbourhood level.

Barriers and opportunities

Interviewees were clear that there are significant barriers and opportunities that lay ahead as they seek to achieve their vision.

First and foremost was a clear message that the current financial environment – for both the NHS and local government – is not only hindering progress but is in some areas actively undoing it. Local leaders in systems managing extreme financial challenge noted that they cannot progress towards the vision outlined above until deficits are overturned and financial

stability is restored, which strains local relationships as partners revert into old ways of working. This issue stems from local leaders' lack of capacity to respond to needs beyond immediate needs, let alone undertaking transformational changes in how health and social care is planned, organised and delivered, but also due to behaviours around accountability and performance management that trickle down from a national level and, in the words of interviewees, "incentivise counterproductive behaviours locally". Our 2024 survey of ICS leaders reflected this, with 87 per cent agreeing or strongly agreeing that their ICB's financial position will impact ICS' ambitions and 86 per cent stating the same for their local authority/authorities.

Some place leaders felt that mature local partnerships should take more ownership over financial recovery. They also noted that current national financial incentives and targets are counterintuitive to successful integration at place level and suggested that place leadership should set its own outcome targets within ICB and ICP frameworks, supported by light touch national guidelines. This is not currently the case, but is particularly crucial to shifting towards a preventative, community-first model of care.

ICBs have needed to respond to significant reductions in their running costs, which is affecting progress towards integration at place. Some systems have straightforward staff reductions of 20-30 per cent reductions across all directorates, maintaining existing models but with downsized teams. Others have used these reductions as an opportunity to rethink their operating models as a whole and consider whether there is a more transformational shift they want to make. Regardless of the outcome of those processes, interviewees were clear that it has had a big impact on progress towards integration and delivery at place.

As demand on health services increases, the financial envelope for meeting this demand is not. Lord Darzi's investigation referenced earlier is very clear on this and goes so far as to say that the NHS budget is not being spent where it should be. This highlights the need for allocating public funds to areas that return the best value for money in terms of impact on population health outcomes. Research by the NHS Confederation and Carnall Farrar in 2023 shows that investment in primary and community care can yield up to £14 in gross value added (GVA) for every £1 invested. This is particularly

relevant given the government's focus on economic growth, with the Secretary of State, Wes Streeting, framing the Department for Health and Social Care as no longer just a health department, but an economic growth department too.

Since many place-based approaches are new, interviewees emphasised the need to demonstrate the impact of their programmes within current financial constraints and present compelling business cases for investment in and delegation to place-based models. Many local leaders noted a dilemma: while integration and place-based approaches are seen as the solution to both immediate challenges and long-term goals, the reality often is, "we can only do this once we've overturned our deficit", which may not be on the immediate horizon. This is not to say that interviewees felt that the answer was simply to increase funding. They recognise this is not possible. Instead, they advocate for a phased approach, implementing programmes, projects and operational changes over a multi-year plan, with support and buy-in from national, system and local stakeholders.

Interviewees sought a clearer view of collective public spending across a place, aiming to integrate budgets across all relevant organisations to support local health and wellbeing. They reported ongoing budget tensions within and between the NHS and local authorities, and desired a unified 'place pound' approach, regardless of the organisation administering it. Pooled budgets were seen as a potential solution, but interviewees felt more could be done. Many referenced the Total Place policy initiative from the 2000s as a model to revisit, believing it could improve community outcomes while driving efficiencies and reducing duplication.

> "Uniting partners around a shared outcome can sometimes prove difficult due to variations in capacity and financial standings, but having all of the right people who are trusted and respected within a system and a community is crucial in breaking down barriers to engagement and collaboration."
>
> Charity partner

Interviewees noted that continually proving the business case takes time and resource capacity away from delivery. When funding shifts towards proactive care instead of supporting financial stability for some local providers, it often requires substantial effort to justify these changes. Interviewees emphasised that tackling inequalities in access and outcomes and wider determinants of health at the place level is crucial to the success of integrated care systems, given the scale of financial and operational challenges.

In the NHS Confederation publication Putting Money Where our Mouth Is?: Exploring Health Inequalities Funding Across Systems, research revealed that half of the systems surveyed devolved additional health inequalities funding to place and/or neighbourhood levels. Some systems used formulas based on deprivation and population size to distribute the funding to best effect.

Regarding the broader operating model for systems, places and neighbourhoods, interviewees identified the extensive and cumbersome nature of planning cycles as a significant barrier to progress. Multi-year funding settlements in both the NHS and local government were seen as crucial for providing more consistency and certainty, allowing local leaders to focus more on delivering what matters to residents. Research by the LGA highlighted the complexity of the funding landscape, noting a patchwork of 51 national programmes, services or initiatives supporting economically inactive people in England. This fractured system was described by interviewees as an unnecessary burden in planning. They felt that too often the burden of governance, while necessary for assurance and risk mitigation, often slows down progress by adding too many layers of meetings, reviews and approval processes.

There is a constant tension between the need for robust governance to ensure thorough consideration and the need for agility and autonomy to drive change. They highlighted the constant dialogue about “what’s done where” to avoid duplication and to ensure clarity within a system. Recognising the diverse stakeholders involved, such as health services, local government, the VCFSE sector, fire, police, and local enterprise, interviewees acknowledged there was a need to “make it work with what we have” as there is no perfect model for systems and the partners that constitute them.

Data sharing emerged as a priority among interviewees, who highlighted the challenge of attaining "buy-in" from all partners within a place for effective data sharing and engagement. The current digital infrastructure, often built around sovereign organisations, was seen as a major hurdle. Interviewees emphasised that this infrastructure would need to be "stitched together over time", to create a more seamless digital experience for patients and the public when interacting with health services.

Spotlight: Identifying targeted health initiatives in Lewisham

Lewisham Health and Care Partners have supported the establishment of four neighbourhood care networks that bring together healthcare services with VCSFE community partners to transform the delivery of community-based care. In building the partnership in South East Lewisham, having a strong foundation of data has enabled the development of targeted health initiatives.

Using the Oracle Health Analytics Platform, health priorities for the area have been clearly identified, guiding the efforts to improve community wellbeing. The platform allows the population health team to query and analyse data from multiple sources, including EMIS, Rio, Lewisham and Greenwich NHS Trust, and service level agreement monitoring. Guided by the data, the partnership has focused on hypertension management and establishing a community cafe facilitated by a health coach. This data-driven approach has ensured that those who are at risk within local communities are identified as a priority, as well as being supported to live well and independently with their condition.

Local leaders are increasingly focused on enhancing representation and involvement of different parts of the health and care system in their partnership. A key area of concern is ensuring that primary care is effectively represented, which has proven challenging in some areas. The NHS Confederation recently published an examination into how primary care provider collaboratives are helping to give voice to primary care at system and place levels. Local leaders may want to explore this further.

> “Working at place takes a lot of time and nurturing in terms of building solid, honest relationships for effective delivery. We cannot underestimate the benefit of bringing an equal voice to each partner when working at place level.”
>
> Charity partner

Conclusion and recommendations

Our research is clear that place is often the scale at which system integration is best delivered. Integration at place can help to tackle both the short- and long-term pressures facing the sector and deliver meaningful improvements to people's experiences of health and care by planning and delivering services more closely with local communities.

As this report details, much excellent work is already being delivered in this way, despite the challenges facing the sector. That said, throughout these interviews, local leaders made several asks of different audiences, including national government, to support the development and enablement of place-based partnerships.

System leaders

1. System leaders should, where beneficial and helpful, **support place leaders to set out realistic timeframes for the evolution of their partnerships** (and integrated neighbourhood working) where this does not already exist. This should include progress towards the devolution of responsibility and decision-making in line with local partnership maturity, recognising the current financial and operating environment, including, when appropriate, protected and recurrent budgets.

2. The NHS and local government (including emerging devolved arrangements such as combined authorities) should **work together as peers to empower place to ensure that the devolution agenda across the country is aligned and complementary in both sectors**, putting places where people live their lives at the heart of public service delivery.

National government

1. **Integration at neighbourhood and place should be at the heart of the Department for Health and Social Care's ten-year reform plan for health**, expected in spring 2025. It should state clearly that this is crucial to achieving the government's ambitions to create a community first, neighbourhood health service, delivering more preventative, proactive care, economic growth, as well as meeting the short-term challenges facing public services. This should also apply to all future health-related integration policy.

    a. **The shift to a community-first approach should be recognised as one of the biggest change programmes in the sector's history** and supported as such.

    b. National leadership should communicate clearly with the sector to acknowledge that this **change requires accepting that greater risk and disruption may be necessary**.

    c. The plan should **consider how regulatory approaches and performance management can adapt** to better enable and encourage collaborative work and innovation focused on preventative, proactive care.

2. The government should **consider a refreshed Total Place policy programme**, assessing how the public pound is spent at place, where people live their lives. This has potential to increase efficiency in line with the government's economic growth agenda, reducing duplication in local delivery, and improve outcomes for local populations by focusing on what works locally.

3. HM Treasury, DHSC and NHS England should **shift the NHS onto multi-year funding and planning cycles, and align these with local authorities**, to enable long-term planning and accelerate integration in budget management, planning and delivery between health and local government.

   a. DHSC and the Ministry of Housing, Communities and Local Government (MHCLG) should together **review Better Care Fund and Section 75 arrangements and consider how they can make pooling budgets easier**, including by reducing the reporting and governance requirements associated with them.

4. DHSC and NHS England should **implement the Hewitt review's recommendations related to how non-recurrent funding is managed**, with fewer stipulations on how it is used locally, and reducing the number of national targets, focusing more on outcomes than activity.

   a. They should also be reviewed to **consider how they can best deliver the government's ambition to create a community-first, neighbourhood health service** (that is, by incentivising the change described under recommendation 1).

5. DHSC, MHCLG, NHS England, the LGA and NHS Confederation should work together to **influence cross-Whitehall policymaking to ensure place is recognised as a crucial delivery mechanism on all issues that relate to health and social care** and to normalise this language and way of working through policy.

What next?

While this work provides only a snapshot of progress, further work will be done on related topics to this, including:

1. Exploring system archetypes and how place and neighbourhood features within them.

2. Learning and development work with system leaders on the future of commissioning.

3. Exploring the link between integration at place and ICSs' fourth purpose of social and economic development, for example, through local growth strategies.

4. Working with our partners, including the LGA, DHSC and NHS England to ensure that the forthcoming ten-year plan for health has a strong focus on integration at place as a delivery mechanism for achieving this government's ambitions.

Appendix 1: Methodology

This research was conducted between February and August 2024 through primary research in the form of one-hour virtual interviews between the NHS Confederation team and a range of stakeholders across integrated care systems.

We conducted interviews with over 60 participants across 25 different integrated care systems and all seven NHS regions in England. We spoke to representatives from integrated care boards (ICBs), local authorities, acute trusts, primary care networks, GP federations and the voluntary, community, faith and social enterprise (VCFSE) sector.

Each interview followed Chatham House rules. Where specific individuals or organisations are named for quotes or case studies, consent has been given to do so.

We also held a series of interviews and a roundtable with place leaders and the Local Government Association to develop and refine the national government recommendations set out in this document.

We would like to extend a particular thank you to the District Councils' Network and the Richmond Group of Charities for helping to facilitate engagement with their members, and to the Local Government Association for supporting this work more widely.

Appendix 2: Related reading

Partners across the sector, including in national government and beyond, have published much supporting work related to the development of place-based partnerships and integrated neighbourhood working. The following is a short reading list of relevant publications:

Publications on integration at place

- Thriving Places, NHS England and LGA. September 2021.
- Health and Social Care Integration: Joining Up Care for People, Places and Populations. Department for Health and Social Care. February 2022.

Publications on integrated neighbourhood working

- Next Steps for Integrating Primary Care: Fuller Stocktake Report. Dr Claire Fuller. May 2022.
- The Case for Neighbourhood Health and Care. NHS Confederation, PPL, Local Trust. October 2024.

Other relevant publications

- Independent Investigation in the NHS in England. Lord Ara Darzi. September 2024.
- Patricia Hewitt's review of integrated care systems. April 2023.

- Place-based Public Service Budgets: Making Public Money Work Better for Communities. Prof John Denham and Jessica Studdert. January 2024.

- Realising the Potential of Primary Care Provider Collaboratives. Fiona Claridge, Shuaib Akhtar, Dr Amit Sethi, Gina Naguib-Roberts. August 2024.

- The State of Integrated Care Systems 2023/24: Tackling Today while Building For Tomorrow. Annie Bliss, Skeena Williamson, Lottie Alayo. September 2024.

- Paving a New Pathway to Prevention: Leveraging Increased Returns on our Collective Investment. Michael Wood, Asha Patel, Ben Richardson. October 2024.

- Unlocking Prevention in Integrated Care Systems. Annie Bliss and Hashum Mahmood. October 2024.

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