Trusts IN SYSTEMS

NHS Providers

PROVIDERS IN PLACE-BASED PARTNERSHIPS

Case studies of local collaboration

JULY 2022

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Case studies of local collaboration

CONTENTS

KEY MESSAGES

- National policy emphasises the importance of place-based collaboration within integrated care systems, as one means to support more integrated, person-centred care for local populations and make best use of collective resources.
- All providers across the acute, mental health, community and ambulance sectors are important partners at place level – alongside primary care, local authorities, social care providers, and voluntary sector organisations. Trusts will need to navigate increasing complexity in systems as they drive vertical integration at place and also work with other trusts as part of at-scale provider collaboratives.
- Trust leaders are optimistic about the opportunities afforded by collaboration at place, including integrating and transforming health and care services, and improving patient outcomes, access and experience. Trusts often see this as part of a longer-term agenda to develop as local anchor organisations, supporting local economic and social development, and working with other partners to shift the dial on health inequalities and the wider determinants of health.
- The role played by trust boards in multi-agency partnerships at place varies. In some cases, trusts enable greater health and care integration through collaborative working or providing infrastructure, expertise or capacity to the partnership. In other cases, trusts are leading the partnership and making place-based working their core business.
- Trust boards play an important role in fostering a collaborative culture and establishing the conditions in which frontline teams can think and work differently. Breaking down barriers to enable staff across the NHS and social care to deliver better joined up care for local communities, in a way that maximises collective resources, is a priority for many trust leaders.
- There is no 'one size fits all' model at place. Partnership arrangements vary across the country, reflecting different local geographies, population sizes and organisational configurations. Trusts and their partners at place know how best to deliver their aims based on an understanding of their local communities, services and geographies. The current flexible and permissive policy framework around place is working well. We urge national policymakers to maintain this flexibility and allow places to design what works in their local context.
- Decisions about pooling and aligning NHS and social care budgets are best taken locally. While funding mechanisms can support integration in some contexts, trusts are clear that such formal changes to funding flows do not guarantee more joined up care. National policymakers should focus on practical enablers of integration – such as shared data and support for a more integrated workforce across health and care – rather than further structural change.
- There are some systemic issues facing health and care services in England which place-based partnerships cannot fix by themselves. If the potential of place-based collaboration is to be maximised, national leaders will need to take action on the long-term fault lines underlying the health and care system, including developing an effective model of workforce planning and supply, securing sustainable funding settlements that reflect changing population needs and properly reforming the social care system.

1 INTRODUCTION

Initiatives to help improve people's health and wellbeing will need a wide range of partners to work together within integrated care systems (ICSs) and place-based partnerships. Trusts are key partners in this work, alongside local government, social care, primary care and the voluntary and community sector. Other sectors that impact the wider determinants of health also have a fundamental role to play, including housing, education and business.

This briefing aims to support the development of successful place-based partnerships by articulating the essential contributions of trusts – as one of several key partners – and exploring how trusts' role at place might evolve over time. It sets out how trusts are involved in strategic place-based planning in partnership with others and in delivering joined up care.

Drawing on five case studies, we set out in practical terms how places around the country are developing their partnership arrangements, and the role trusts are playing in them. These places were chosen to demonstrate the variation in how partnerships are developing based on their size, context and population needs. We chose places with a range of experiences and approaches, and interviewed some of the trust leaders, across acute, mental health, community and ambulance sectors, working in those places.

By exploring a range of leadership and decision-making arrangements, we hope to demonstrate that there is no 'one size fits all' model for working at place. There are many ways that trusts are working with partners to improve care for local communities, and we suggest a set of recommendations for national policy makers to maintain this flexibility as we move beyond the Health and Care Act 2022 into implementation.

Context: the new system architecture

The NHS in England has been changing for some time. National policymakers and local service leaders are seeking to promote and embed collaborative ways of working across health and care services. This shift to system working has been driven by the need to provide better joined up care to the growing numbers of people who rely on multiple health and care services.

Since 2021, all parts of England have been working as 42 ICSs, which bring together NHS organisations with key partners including local authorities and the voluntary sector, to coordinate and plan health and care services to meet the needs of the local population. ICSs cover populations ranging between 600,000 and three million. National policy identifies four key purposes for ICSs:

- improving population health and healthcare outcomes
- tackling inequalities in outcomes, experience and access to health care
- boosting productivity and value of health care
- supporting broader economic and social development in local communities.

The Health and Care Act came into effect in July 2022 making wide-ranging changes to the legislative framework underpinning the NHS, aimed at facilitating greater collaboration and integration. Under the new legislation, ICSs will become statutory bodies with a two-part structure comprised of an integrated care board (ICB) and an integrated care partnership (ICP).

ICBs will manage NHS funding and performance. They will include members from trusts, local government and primary care. ICPs will be formed in each ICS as joint committees of ICBs and the relevant local authorities in the system, bringing together a range of local stakeholders to create an integrated care strategy that meets the health, care and wellbeing needs of local populations.

While this two-part ICS structure aims to bring NHS organisations, local authorities and wider partners together to plan and deliver services differently, it has not altered the fundamentally different accountability structures between the NHS and local government. Navigating this complexity when developing local priorities will remain a key challenge for systems and place-based partnerships, particularly in systems which have several local authorities of differing political complexions or potentially divergent priorities.

National policy developments relevant to place

Recognising that place is a key footprint for implementing integration, national policy has aimed to support partners to work together effectively at place level (alongside guidance focused on supporting collaboration between trusts at ICS and multi-ICS level).

In 2021, NHS England published an **ICS design framework** which made clear that place partnerships would be characterised by collaboration across the NHS, local government, voluntary sector and wider partners. The ***Thriving places*** guidance, also published in 2021, positioned place-based partnerships as the building blocks of ICSs, and identified a number of functions which may be well suited to being led at place, including strategic planning, leading service change, population health management, connecting with local community insight and facilitating action on wider determinants. Places will need to establish shared objectives and vision, built on a mutual understanding of the population and their health aspirations.

In February 2022, the government published an **integration white paper** which sought to help accelerate the integration of health and social care services at place level. It articulated some expectations for places, including:

- places are asked to clarify leadership arrangements by spring 2023 via identifying a single person accountable for delivering shared health and care outcomes
- places will develop joint outcomes for health and care services, informed by a national outcomes framework (both are expected in spring 2023)
- places are asked to explore growing the proportion of health and care budgets that they manage using pooled or aligned arrangements (such as section 75 agreements).

The Department of Health and Social Care (DHSC) led an engagement process on the white paper in Spring 2022, and we submitted **a response summarising trust leaders' views**. The outcomes of that consultation and next steps on implementation of the white paper's proposals are expected to be made clearer in the coming months.

Places within integrated care systems

Trusts have been working with each other and wider partners in a range of formal and informal collaborative arrangements for many years. Their experiences of implementing service change, including during the pandemic, have demonstrated that, in many systems (though not all), much of the work to join up care happens naturally at smaller footprints than ICSs.

Systems have defined place footprints locally, often based on local government boundaries and/or hospital patient flows. ICSs vary in how many places they cover, depending on a number of factors such as population size, geography and organisational configurations. Similarly, the relative roles and responsibilities held at system and place levels within ICSs is subject to local variation.

In many cases, partners have developed collaborative arrangements – of varying degrees of formality – at place to support their shared purpose. Different terminology has been used to refer to these place-focused collaborations, or programmes of work, including integrated care partnerships, alliances, localities etc. As system working has evolved, trusts have supported system-wide aims by working in more collaborative and integrated ways, as explored below.

Key themes of trusts' work at place

Trusts of all sectors have a role at place – but those roles will rightly differ depending on the local context, geography, and population size, as well as the nature of the services they provide. Looking across the sites we spoke to, the roles that trusts are adopting at place fall into broad themes:

- planning, delivering, integrating and transforming services
- improving population health and wellbeing, and tackling health inequalities
- workforce planning and development
- leading and directing their organisations to facilitate partnership
- supporting a collaborative culture.

A number of trusts providing services at scale, including ambulance trusts and colleagues across community services, mental health and acute care, will be balancing the need to work collaboratively at scale with a smaller population focus. This will prove a challenge for those trusts whose services are predominately at scale, as each place will have its own distinct culture and priorities.

Planning, delivering, integrating and transforming services

People access the majority of health services in the places they live. In many systems, it will make sense to plan and deliver some of these services at place level, such as non-complex acute care, surgery and diagnostics, and community services for physical and mental health. Urgent care services are also likely to be an important collaborative endeavour at place. Many of these services are being transformed and integrated with wider health, care and public services, as trusts work with partners to join up care and redesign end to end care pathways. Many trusts have the capacity and capability to add significant value to this service transformation and improvement agenda at place level.

Improving population health and wellbeing, and tackling health inequalities

Trusts are establishing themselves as anchor institutions in their places and communities in several ways. As large employers within and across places, trusts have scope to positively influence the socio-economic development of their local areas, and in turn the health and wellbeing of their local populations, through the choices they make around employment and purchasing decisions. They also have opportunities to positively impact local communities, tackle health inequalities and shape the wider determinants of health through their collaboration with local government. Some trusts are also building partnerships with wider public services in their places, e.g. working with education institutions to encourage participation and broaden career paths.

Workforce planning and development

Trusts are supporting and developing integrated workforce arrangements at place level including across health and social care services. As trusts employ 1.2 million NHS staff, they have helpful insights into how hyper-local joint working across health and care can make a tangible difference to patients and service users, and allow staff to maximise their skills. Increasingly, trusts are supporting local approaches which enable places to understand their collective workforce resource and capabilities, harness the potential of integrated multidisciplinary teams and career paths, and look for opportunities to deploy staff differently.

Leading and directing their organisations to facilitate partnership

Our case studies show how trusts are playing varied roles at place level depending on their organisational size, configuration and local context. Some trusts are taking a leadership role, leading programmes of work, acting as a host for collaborative arrangements, and delivering key capabilities on behalf of the partnership. In some cases, this includes trust senior executives leading the place partnership alongside their substantive roles, with support from local partners. In other places, trusts are taking more of a supportive role; for instance, deploying their resources and infrastructure to support the partnership's aims, supporting other organisations to lead the partnership following local agreement, and ensuring their

trust's operational model dovetails effectively with the place-based partnership(s) to which they contribute. In all cases, trust boards remain responsible for the services their organisation delivers, so they continue to manage organisational priorities and oversee care quality, alongside partnership-focused work.

Supporting a collaborative culture

A recurring theme throughout our discussions with trust leaders was the importance they placed on a culture of collaboration, as an enabler of service change and improvement. They also noted that decisions about leadership and partnership arrangements, though important, are in practice dependent on leaders and operational teams fostering a sense of shared endeavour based around serving the local population. Whatever leadership and partnership management arrangements are chosen, it is essential that they have been designed to fit local circumstances with input from participating organisations and therefore enjoy the genuine support from partners within a place. As our case studies show, there is no 'one size fits all' model at place level.

Provider collaboration

Alongside collaboration at place, trusts are working together to support the delivery of ICSs' four key purposes. Provider collaboratives, partnerships of two or more trusts, will play a leading role progressing a number of key agendas such as driving standardisation in clinical services, reducing inequalities in access to care and making health services more resilient through sharing staff and other resources between sites and organisations.

From July 2022, NHS England expects all acute and mental health trusts to be part of at least one collaborative, with other trusts, such as community and ambulance trusts, forming or joining collaboratives where it can support improvements in care. Although not the main focus of this piece, provider collaboratives will interface with place-based collaborations and many trusts will contribute to place-based partnerships alongside working as part of a collaborative(s).

To find out more, please see NHS Providers' successful programme of influencing and support for provider collaboration.

BOLTON

2

Background and context

ICS

Greater Manchester (GM) ICS, which evolved in the context of a bespoke devolution deal from central government from April 2016.

Number of places in the ICS

Ten localities.[1]

Key partners in the Bolton locality

- Bolton NHS Foundation Trust (physical acute, specialist and community health services)
- Greater Manchester Mental Health NHS Foundation Trust (delivers a range of mental health services across several GM boroughs, including Bolton)
- North West Ambulance Service NHS Trust
- Bolton Council, which is a metropolitan borough and unitary authority
- Greater Manchester integrated care board (ICB), which will have a Bolton presence (formerly NHS commissioning functions were led by Bolton CCG)
- Voluntary and community sector
- People and local communities.

Key features of the Bolton population

- 290,000 people
- Over one fifth of the local population are from Black, Asian and minority ethnic backgrounds
- Higher-than average levels of deprivation and lower-than-average life expectancy for both men and women.

Role of the trusts at place

For trusts in Bolton, working through the place partnership represents an opportunity to address health inequalities, transform how care is delivered across organisational boundaries and improve the health and wellbeing of local people. Bolton NHS Foundation Trust envisages a future as an integrated health and care organisation, taking on some planning and oversight functions, and coordinating integration across a spectrum of local services in partnership with other organisations including the voluntary sector and primary care. Greater Manchester Mental Health NHS Foundation Trust is developing its strategic planning role beyond specialist mental health services, supporting a tailored offer at place level and supporting transformation of adult secure mental health services through a provider collaborative arrangement.

1 Greater Manchester refers to its place-based partnerships as localities, reflecting the ten metropolitan boroughs that sit within the Greater Manchester area.

Decision-making arrangements

Health and care organisations in Bolton formed a partnership several years ago to support closer collaboration. This has involved changing ways of working for all partners, including trusts. For Bolton NHS Foundation Trust and Greater Manchester Mental Health NHS Foundation Trust, the focus has been on developing a provider partnership at place level – known as an integrated care partnership.[2]

The place-level partnership aims to enable clinical and operational teams to work together more closely and deliver care in ways that meet people's needs at the earliest opportunity and help them to stay well where possible. The partnership was formed as an 'alliance', which aims to support operational collaboration without formally affecting partner organisations' sovereignty.

At the heart of the place approach is the development of integrated neighbourhood teams and primary care networks, which bring together professionals from a range of partner organisations and services – secondary care services, primary care including general practice and community pharmacy, social care and other local government capabilities such as housing advisers – to focus on tailoring local community-oriented services to needs within the nine neighbourhoods in Bolton, each of which serve populations of around 30-50,000.

All aspects of the Bolton partnership programme are overseen by the multi-disciplinary Bolton locality partnership board, which includes the trusts delivering services in the locality. The locality board reports to the Greater Manchester ICB which will hold the locality board to account for functions delegated to place, and the Bolton Health and Wellbeing Board, which holds the locality board to account for delivery against aspirations outlined in the health and wellbeing strategy and the Bolton locality plan.

Leadership model

Prior to the introduction of the Health and Care Act, Bolton opted for a blended model of leadership, with senior leaders in organisations taking on place-focused responsibilities alongside their substantive roles. The Bolton place partnership has a managing director and an independent chair, hosted by Bolton NHS Foundation Trust but accountable to all partners. These roles provide management and leadership capability at the interface between health and care, as the managing director also holds the role of director of adult social services at Bolton council.

Looking to the future, Bolton NHS Foundation Trust's chief executive will serve as the place-based lead for health and care. As place lead, they will report jointly to the Bolton locality board and the Greater Manchester ICB for the strategy and planning of delegated aspects of health and care in Bolton. Formal accountability for the delivery of NHS services will continue to sit with the foundation trust and with Bolton Council for council-funded services.

2 In some cases, including Bolton, place-based delivery partners are collectively referred to as integrated care partnerships (ICPs) to reflect their joined-up work. However, this reference to ICPs at place is not to be confused with the statutory integrated care partnerships operating at system level, as required by the Health and Care Act 2022.

Approach to managing collective resources

Traditional boundaries between NHS commissioning and provider functions have been blurring in Bolton for several years, as partner organisations worked together to make best use of local skills and resources for the benefit of the local population. Bolton NHS Foundation Trust moved towards a shared model of financial performance monitoring and oversight with the CCG, including closer working across finance teams to develop a place-based lens on NHS resources. This was supported by the Bolton NHS Foundation Trust chief finance officer also serving as chief finance officer for the Clinical Commissioning Group (CCG). To enable this, Bolton NHS Foundation Trust hosts some shared planning and support functions, such as business intelligence and digital services which deliver for the trust and CCG.

Similarly, NHS and local government planning bodies have sought to unlock new opportunities to plan services more holistically and simplify decision making by working through a single commissioning function. This has seen them bring capabilities together as far as possible, including public health expertise, analytical capabilities, and service improvement expertise. This has been underpinned by a pooled budget arrangement, using a section 75 agreement, focused on jointly planning mental health, learning disability, and some community and adult social care services. This enables resources to be collectively managed as part of a strategic, streamlined approach to planning health and care services.

The intention is that this approach will be extended under the new legislative framework. The integrated business intelligence team will be expanded to include council functions; the NHS and council commissioning functions will continue to bring together their strategy and planning processes; and there will be shared finance and transformation oversight to support joint working through all stages of public service planning and delivery within Bolton.

Benefits and learning

Deepening collaboration at place in Bolton has made it possible to tailor local service offers based on the trusts' and wider partners' local intelligence and community connections. For instance, the place partnership's focus on working in communities has supported improvements to community support for pregnant women in Bolton, including supporting women who experience pregnancy loss, with an emphasis on cultural inclusion and working with communities to develop an understanding of ethnic minority communities.

Additionally, commitment to partnership working is helping the trusts and their system partners manage challenging demand pressures. While challenges remain, patient flow through secondary care settings in Bolton is performing better than some other geographies, which leaders attribute – in part – to good relationships that have been built over the last few years.

Looking to the future, partners in Bolton see their existing collaboration as a platform on which they can build, leaning into the national emphasis on place and developing a more ambitious model of public service collaboration at place. For Bolton NHS Foundation Trust and Greater Manchester Mental Health NHS Foundation Trust there is scope to develop the place partnership way of working to bring services together more effectively, working with partners including the local authority, primary care and the voluntary sector, and make different choices about how resources are used based on the needs of Bolton's residents, including gradually ensuring proportionate investment in mental health care.

3

CROYDON

Background and context

ICS

South West London ICS.

Number of places in the ICS

Six borough-based places: Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth.

Key partners in the Croydon place

- Croydon Health Services NHS Trust delivering acute and community health services
- South London and Maudsley NHS Foundation Trust (SLaM) provides mental health and learning disability services across a number of London boroughs, including Croydon (as well as a range of specialist services across a larger footprint)
- London Borough of Croydon, which is a unitary council with a directly elected mayor (as of May 2022)
- South West London ICB (formerly commissioning functions were led by South West London CCG)
- Croydon GP Collaborative
- Age UK Croydon.

Key features of the Croydon population

- 380,000 people
- One of London's fastest growing and most diverse boroughs, with a large community of people from ethnic minority backgrounds (estimated at around half of the population) and a large number of people in the Core20Plus5 cohort (which includes: those living with deprivation; poorer than average access to, experience of, or outcomes of care; and health inclusion groups such as people experiencing homelessness, traveller communities, and people in contact with the justice system)
- Significant health inequalities: life expectancy for men, for instance, varies by up to 10 years between different parts of the borough.

Role of the trusts at place

Croydon Health Services NHS Trust has helped lead the development of the place partnership within the borough, providing leadership and organisational capacity to the programme. The chief executive of the trust is also the place-based leader, which has enabled the development of more integrated services between primary, secondary, community and social care, and supported greater emphasis on population health. In the future, there is scope for it to develop its role further, working more closely with other partner organisations, providing a broader spectrum of services, contributing to a population health agenda, and supporting greater coordination across organisational boundaries.

Decision-making arrangements

Reflecting Croydon's comparatively simple organisational context – a single trust delivering both acute and community services, and a co-terminous local authority (and previously co-terminous CCG) – partners in Croydon have sought to work through a relatively streamlined model for leading and delivering place-based working.

Initially, this took place under the auspices of the One Croydon Alliance, a partnership between a group of health and care organisations with a focus on services for older people (aged 65 and over). In time, the agenda developed to include services for the whole population. Additionally, in 2019, Croydon CCG and Croydon Health Services NHS Trust developed proposals to align their functions and ways of working to create an approach to health care planning and delivery that would support their aspiration to develop a truly 'place-based' model of care.

Prior to the introduction of the Health and Care Act in which CCGs were abolished, Croydon Health Services NHS Trust and Croydon CCG worked collaboratively over several years and effectively operate as a single organisation with a single financial control total. All key decisions relating to strategy, transformation and finance were taken at 'committees in common' made up of executives, NEDs and lay members of both organisations. The committee in common was underpinned by an MOU between the key provider organisations, which formed the main vehicle for delivering change in how services are delivered.

A health and care board oversees transformation work in Croydon, where partners come together to make decisions and discuss operational priorities and assess delivery progress. As in other places, the health and wellbeing board (HWB) for the borough articulates the broad aspirations for the local population through its health and wellbeing strategy. The One Croydon Alliance then uses this strategy to inform its collective programme of change.

The alliance arrangement provides a single forum where partners can collectively articulate strategy and set shared priorities, for instance the alliance developed a shared health and care plan for Croydon. However, in line with the legal framework, these arrangements do not affect the legal status of the trust: the trust board remains in place and responsible for their respective statutory duties.

Working through an alliance creates scope to introduce service developments drawing in a broad range of local partners' capabilities and informed by an understanding of local communities' strengths and needs. For instance, SLaM works with VCSE partners in Croydon to deliver support and recovery services – in community settings – which are designed around local people's needs and with a strategic focus on promoting cultural inclusion, responding to the diversity of the borough's population.

For Croydon Health Services NHS Trust, their role supporting collaboration at borough level sits alongside active involvement in the south west London acute provider collaborative,

which brings together the four acute trusts in the system: Croydon Health Services NHS Trust, St George's University Hospitals NHS Foundation Trust, Epsom and St Helier University Hospitals NHS Trust and Kingston Hospital NHS Foundation Trust.

Leadership model

Croydon has moved to a shared leadership team for their place-based partnership. Since October 2020, Matthew Kershaw has been chief executive of Croydon Health Services NHS Trust and managing director for Croydon CCG with a shared leadership team including a joint chief nurse, joint chief finance officer, and joint director of strategy and transformation working across both organisations. This model has been a key enabler of breaking down organisational boundaries between partner organisations with a view to deploying local management capabilities – finance, clinical leadership, strategy and transformation – more effectively.

Approach to managing collective resources

Over time, leaders in Croydon have been nurturing a shared approach to financial resources and increasingly looking for opportunities to deploy resources for the long-term benefit to the health of local populations. In operational terms, there are a couple of key aspects to this.

Firstly, in line with national expectations around the Better Care Fund, the CCG and council entered into a section 75 agreement to pool a proportion of their budgets to support more joined up working across health and care services. This work programme has focused on funding community-oriented services and improving reablement and rehabilitation care. The pooled arrangement is overseen by the Croydon HWB.

Secondly, Croydon Health Services NHS Trust and Croydon CCG developed a risk share arrangement whereby the two organisations' resources were effectively pooled and operated a joint control total. Both organisations committed to a 50/50 allocation of risk for deviating from financial plans. The aforementioned joint governance and leadership model supported this way of working. This arrangement was suspended when NHS England introduced special financial planning arrangements to support the NHS response to COVID-19.

Looking ahead, partners in Croydon want to develop this model further now that the new legislation has come into effect. A place-based lead for health, as outlined by the integration white paper, will be a continuation of the approach previously in operation across Croydon Health Services NHS Trust and the CCG. Discussions are ongoing about the details, but South West London ICB is supportive of delegating substantial resources to place level. The alliance arrangement will provide a platform with capabilities to further develop integrated planning and delivery in Croydon.

Benefits and learning

For Croydon, having a trust chief executive as the place-based leader has been beneficial and facilitated a different lens on traditionally health-based issues. For example, when looking at urgent and emergency care as both a trust leader and a place-based leader, it is easier to see how pressures in this pathway are partly influenced by the health needs, inequalities and unmet needs of the local population. Having this consideration of the wider determinants of health can generate a set of place-based priorities and objectives that partner organisations can support, to the benefit of patients and communities.

The alliance approach also provides a framework to bring together key players at place level – acute, community, mental health and primary care services – to collectively address those priorities over time. Croydon Health Services NHS Trust is also carrying out a piece of work to take forward NHS England's Core20Plus5 model of tackling health inequalities and is considering what this means for the trust's work. This population health focus is a result of the place lens and demonstrates the importance of senior leadership buy in.

4

LEEDS

Background and context

ICS

West Yorkshire ICS.

Number of places in the ICS

Five.

Key partners in the Leeds place

- Leeds and York Partnership NHS Trust providing mental health and learning disability services to the city's population and specialist services on a regional basis
- Leeds Community Healthcare NHS Trust providing adult and children's community health services to the city
- Leeds Teaching Hospitals NHS Trust which provides acute and specialist services across five sites to patients from Leeds, Yorkshire and Humber and beyond
- Leeds City Council, which is a large unitary authority
- Leeds office of the West Yorkshire ICB (commissioning functions previously held by Leeds CCG)
- Primary care services, including Leeds GP Confederation, a membership organisation for the approximately 90 GP practices in the city
- Social care providers
- A range of voluntary and community sector organisations.

Key features of the Leeds population

- Around 800,000 people, with a growing population
- Leeds has a diverse population, including an unusually large student body thanks to several universities being based in Leeds
- Wide health inequalities, including a life expectancy gap of around 14 years for women and 12 years for men
- Leeds is a growing economic centre, with around 125,000 businesses in the city, although the population also sees some challenges around economic inactivity and deprivation.

Role of the trusts at place

In Leeds, trusts are taking a collaborative approach to developing place arrangements and are playing leadership roles in different ways alongside local government, the voluntary sector and wider partners. This includes supporting strategic planning processes; increasing operational collaboration to design new service delivery models across traditional organisational boundaries, including with a range of local government services; modelling a culture of joint working; and shifting towards a conceptualisation of a shared 'Leeds pound' (without requiring structural changes to funding flows).

All three trusts have important roles as anchor organisations, contributing to the wider determinants of health through their roles as employers and purchasers of goods

and services. As part of this work, Leeds Teaching Hospitals NHS Trust is investing in a redevelopment programme for a new wing of Leeds General Infirmary and plans to create an innovation village to bring in investment and jobs. This is all part of the bigger agenda to make Leeds a prosperous and healthy place to live.

Decision-making arrangements

Partners in Leeds have been working together to improve health and care services for a number of years. Leeds Health and Wellbeing Board (HWB) provides a focus for articulating health and care ambitions for the population through its health and wellbeing strategy, which aims to make Leeds a healthy and caring city, with a particular emphasis on improving the health of people living with deprivation.

A partnership executive group, formed in 2015, brings together executive leaders of the trusts and wider partners including VCSE and primary care to lead on the implementation of agreed priorities. It reports to the HWB on a quarterly basis on progress, including on operational and financial performance. Several leaders of statutory organisations also sit on the HWB – thereby spanning the strategic and operational leadership forums.

As the West Yorkshire ICS has matured, with the ambition for places to lead many key functions by default, partners in Leeds have been exploring how to build on and strengthen their existing arrangements to mobilise shared resources more effectively and deliver against core objectives. This has led to the creation of a formal place-based partnership, known as the Leeds health and care partnership.

The partnership will be underpinned by an operating agreement and a formal joint committee, which will outline the relationship between the partnership arrangement and its constituent organisations and enable the delegation of a budget from the West Yorkshire ICB.

The partnership's work programme is shaped by a shared strategic plan (the Healthy Leeds plan), formally led by Leeds CCG, which sets out several programmes of work. The strategic plan includes a set of indicators which will be tracked to assess whether the partnership's collaborative work is generating impact. The indicators fall into three key categories:

- health outcome measures, such as infant mortality rate and healthy life expectancy
- system activity measures, such as reduction in the rate of growth in A&E attendances
- quality experience measures, such as patients' experience of inpatient hospital services and experience of primary care services.

Leadership model

To date, partners in Leeds have intentionally sought to embed a fairly lean leadership model, drawing on leaders from across participating organisations, rather than creating new roles. Key executives are part of the partnership executive group, chaired by the council

chief executive, which has evolved over time to reflect how the agenda has become more ambitious. This group considers estates strategies, public and patient engagement plans, and solutions to collective challenges.

Looking to the future, place-based governance arrangements will evolve and there will be a Leeds place committee of the ICB, including an independent chair and non-executives. This will be separate to the HWB but still hold close relationships. The current CCG Accountable Officer will take on the place-based lead role for Leeds, employed by West Yorkshire ICB. The exact details of how the place lead role will function will develop with time. Responsibility for service delivery will continue to sit with trust boards. The work of place-based planning infrastructure will be supported by a Leeds office of the West Yorkshire ICB, hosting staff formerly employed by Leeds CCG.

Approach to managing collective resources

Like other parts of the country, Leeds has pooled budgets through the Better Care Fund. Since 2019, it has worked through an integrated commissioning executive, drawing on capacity from both Leeds CCG and Leeds City Council (including some joint roles). Pooled spending has been largely focused on mental health care and learning disability support, intermediate care and at-home reablement support to promote timely discharge from hospital settings.

Additionally, organisations in Leeds have for some time been flexible in how funding is allocated, to enable the best use of public resources locally while also meeting national expectations and statutory requirements.

The details of system financial management from July 2022 are subject to ongoing development, but the West Yorkshire ICB plans to support financial delegation to places through establishing committees of the ICB. Place committees will lead on: agreeing plans to meet local needs; allocating resources to meet priorities; contracting for the delivery of services; and overseeing progress against the plan and ensuring local people's views are embedded in ways of working. These functions will be discharged through a sub-committee structure, likely covering quality and finance.

Benefits and learning

One of the key achievements of partnership working in Leeds has been the establishment of the Leeds Health and Care Academy, which is comprised of the trusts, Leeds City Council, Leeds CCG, Leeds universities and the VCSE sector. The academy is a key partner in responding to the city's workforce challenges, working on behalf of the entire Leeds health and care sector to design and deliver collaborative learning and development programmes for all staff. Since its formation, the academy has improved the recruitment and retention of health and care staff across the city. It has also used partnership working to provide employment opportunities for those in the most disadvantaged communities to ensure Leeds has a diverse, skilled workforce both now and for the future.

5

NORTH EAST ESSEX

Background and context

ICS

Suffolk and North East Essex ICS.

Number of places in the ICS

Three.

Key partners in the North East Essex place

- Essex Partnership University NHS Foundation Trust which delivers community and mental health services.
- East Suffolk and North Essex NHS Foundation Trust provides acute and specialist physical health services in North East Essex – it is a large acute trust delivering services across multiple hospitals sites in both Suffolk and North East Essex ICS and Mid and South Essex ICS
- The East of England Ambulance Service NHS Trust delivers ambulance and other emergency care services across the region, including in North East Essex
- Essex County Council, which is an upper tier local authority
- Colchester Borough Council
- Tendring District Council
- Suffolk and North East Essex ICB (formerly commissioning functions were led by North East Essex CCG)
- Primary care services
- Voluntary and community sector organisations.

Key features of the North East Essex population

- 360,000 people
- Mix of urban and rural communities, including some coastal communities which are among the most deprived in England.

Role of the trusts at place

The trusts working in the North East Essex place have a key role in developing and promoting new models of care that can keep local people well in the community, and tackle health inequalities. The trusts in the footprint, all of which operate over multiple place geographies, contribute as strategic and operational partners in the place, contributing service design expertise, providing leadership capability via the alliance, and developing bespoke place-focused collaborative programmes for North East Essex.

Decision-making arrangements

Since 2018, health and care partners in North East Essex have been developing a place-based partnership, called the North East Essex Alliance (NEE Alliance). The NEE Alliance has developed its model and ways of working over the last few years: broadly it has moved from

being a comparatively informal grouping of local partners, overlaid on traditional planning and commissioning structures, towards becoming a more formal part of the local architecture that facilitates collective decision-making on resources and operational coordination.

One aspect of this shift was the decision to effectively 'house' the NEE Alliance within the North East Essex CCG. The CCG governance structure was adapted to establish an Alliance Committee as a sub-committee of the CCG Board. The Alliance Committee comes together to set the strategic direction for the alliance, with a focus on investing in prevention and reducing health inequalities, implementing an asset-based community model of care, building system resilience, and taking a joined-up approach to workforce planning.

An Alliance System Executive Group (SEG) brings together executive leaders from the partnership organisations. This group leads on implementation and operational decision-making in pursuit of the direction of travel set by the Alliance Committee. Different workstreams for the partnership, which are organised using a life course approach, report to the executive group. The Alliance's strategic objectives have been informed by the Essex health and wellbeing strategy, which provides a county wide view of the population's health aspirations.

Leadership model

Throughout its existence, the NEE Alliance has modelled multi-agency collaboration in its leadership team. Executive leads from the partner organisations participate in the alliance SEG and lead specific portfolios, alongside their substantive roles in providers or commissioners. The Alliance has sought to ensure some focused non-executive oversight at place level through appointing a chair drawn from the partner organisations. The trusts have reorientated their operational divisions to places; for instance, Essex Partnership University NHS Foundation Trust has created place-focused operational leads for community and mental health services.

Approach to managing collective resources

NHS commissioners and local authorities have worked together to align decision-making where it makes sense, but have not entered into pooled budget arrangements, beyond meeting national expectations around the Better Care Fund. Oversight of the Better Care Fund arrangement for the CCG has sat with the Alliance Committee.

Leaders have increasingly sought to model a mindset of managing resources collectively with minimal technical changes. In that context, alliance forums have provided spaces where leaders can collectively discuss how to prioritise resources and identify opportunities for synergies.

Going forward, the intention is for the NEE Alliance to become the default forum for all key commissioning decisions, acting as a sub-committee of the ICB, and will work with partners across the ICS wherever this will add most value. Similarly, it is expected that alliances will

form the basis for the commissioning and management of the Better Care Fund, supporting closer joint working between NHS and local authority services.

Benefits, learning and future priorities

North East Essex has developed in this way for a number of reasons: it is a place within a large two-tier local authority; it is part of an ICS that bridges two upper-tier counties; and the trusts operating in North East Essex are delivering services across more than one place.

Notwithstanding these inherent complexities, the NEE Alliance has provided a focal point for deepening collaboration across the NHS and social care, between trusts, and with wider partners. The trusts see further potential in developing a joined up approach to local planning and delivery.

Trusts in North East Essex also see place-based collaboration as enabling operational improvements, and supporting system partners to think differently about how care models can support early intervention and promote wellbeing. East of England Ambulance Service NHS Trust has identified opportunities to trial new ways of working, for instance, trialling a scheme in which paramedics work more closely with local hospices. East Suffolk and North Essex NHS Foundation Trust and Essex Partnership University NHS Foundation Trust are core partners in a new consortium, along with a range of others including primary and voluntary sectors, to develop an integrated community services offer in North East Essex.

6

SOMERSET

Background and context

ICS

Somerset ICS.

Number of places in the ICS

One place, coterminous with the ICS.

Key partners in Somerset

- Somerset NHS Foundation Trust, delivering acute, community and mental health services
- Yeovil District Hospital NHS Foundation Trust delivers acute hospital services for people mainly living in the south of the county; Yeovil and Somerset NHS Foundation Trusts are operating with a shared leadership team and plan to merge in April 2023
- Ambulance services are delivered by South Western Ambulance Service NHS Foundation Trust
- Somerset County Council, which is co-terminous with the ICS, also works with four district councils. In 2022 it was confirmed that would merge with the district councils in the footprint to establish a unitary authority in April 2023.

Key features of the Somerset population

- Around 600,000 people
- Relative to the rest of England, the population is older, more geographically dispersed, and less deprived, although there are substantial inequalities with pockets of deprivation in some urban and coastal communities in Somerset.

Role of the trusts at place

The two trusts in Somerset have played a critical role in shaping and implementing the ICS's strategic priorities. Plans to establish a single integrated trust – spanning acute, community and mental health services (and directly delivering some primary care) – for the ICS aim to stabilise services, address unwarranted variation, drive up clinical quality and develop new community-oriented care models. The trust will be unique in the breadth of services it delivers to a whole ICS population, and may be well-situated to assume further responsibilities for driving greater integration across NHS services, and with local government services in future.

Decision-making arrangements

In organisational terms, Somerset is a comparatively simple system. From April 2023, the ICB will be co-terminous with a unitary local authority, and the county's acute, community and mental health services will all be provided by a single trust from April 2023 (subject to the planned merger completing on schedule).

In Somerset, place and system footprints are the same. Functions often associated with place-based partnerships – leading joint work with local government, developing approaches to address inequalities and building partnerships with voluntary sector organisations – are led across Somerset. Partners are then focused on service delivery at a neighbourhood level.

To date, the Somerset ICS has set the strategic direction and shared priorities, promoting collaboration, and providing a forum for constructive mutual challenge. Key executive leaders from the statutory organisations within the system, including the trusts, primary care and voluntary and community sector, formed a sub-group to lead on implementing decisions agreed via the ICS board. A primary care board was established in 2020 to be a collective voice to general practice in the county, and the voluntary and community sector.

Building community-oriented capabilities is a central theme of the strategy and, in turn, neighbourhood working is a key feature of the change programme in Somerset. Multidisciplinary neighbourhood teams – developing an 'integrated out of hospital offer' – are bringing together primary and community services alongside voluntary sector partners, working with primary care networks in the area. The trusts are supporting this agenda through how they deploy their community nursing capabilities, mental health and dementia support for older people, and deepening collaboration with Somerset County Council on intermediate care.

Looking to the future, the system-level integrated care partnership (ICP) for Somerset has an opportunity to articulate a shared set of outcomes across the NHS, local government and wider stakeholders. It is expected that the ICP and health and wellbeing board (HWB) will operate in concert, with the ICP potentially operating as a sub-committee of the HWB, supporting coordination with existing health and wellbeing strategy process, and informed by public health expertise and analysis held by the unitary authority.

Leadership model

Looking ahead, leadership capabilities in Somerset are likely to continue to be deployed largely at a county wide footprint and at neighbourhood level. The key executive leaders – in the trust, ICB and local authority – will continue to come together regularly to lead and coordinate implementation of change programmes.

To support this, the ICS envisages developing a shared delivery function that will lead on implementing an agreed set of programmes. Key capabilities will include programme management, transformation support, service improvement and communications. This function will initially operate as an amalgam of partners' capabilities, with shared leadership and staff seconded by the key participating organisations – ICB, local authority and trust. In time it may be formalised and be hosted by a single partner organisation.

Approach to managing collective resources

In addition to complying with the national requirements of the Better Care Fund policy, Somerset CCG and the County Council managed several pooled budget arrangements in priority service areas including carers support and services for people with learning disabilities and/or autism. Disability services have been a long-standing area of collaboration and substantial budget pooling for the NHS and local government in Somerset. A joint commissioning board, hosted by the county council, has been in place for several years, overseeing resource allocation decisions, accountable to both the County Council and CCG. Somerset ICB will take on these arrangements in 2022/23; discussions are ongoing about how best to evolve joint planning arrangements in Somerset within the new legal framework.

Benefits and learning

The development of the ICS in Somerset has not been without challenge. However, system partners have been working closely together to improve outcomes, access and experience for the local population. For example, trusts and partners working in the Somerset ICS have developed a shared strategy and framework for operational change, which is supporting practical collaborative initiatives to benefit patients – such as ongoing joint work to address delayed discharges and a programme of work to develop the intermediate care offer. The strategy also covers the ICS's ambitions to improve the health and wellbeing of local communities and neighbourhoods. An example of this work is encouraging people to develop networks of support, particularly for vulnerable groups.

Developing ways of working between Somerset NHS Foundation Trust and Yeovil NHS Foundation Trust are broadening the capabilities deployed in neighbourhoods across primary and secondary care. This collaboration will provide a simplified access route for local people needing primary health services, social care support and wellbeing support.

7 RECOMMENDATIONS FOR NATIONAL POLICY MAKERS

Drawing on the five case studies and our wider engagement with trust leaders, there are several areas where national policy makers can support trusts to fulfil their role – as they have defined it locally – in place-based partnerships:

- **It will be important to maintain a flexible and permissive national policy and legislative framework**. This will allow trust leaders and system partners to develop place-based partnerships, including leadership and partnership arrangements, that make sense in their unique local contexts and avoid creating additional bureaucracy. This flexibility was welcome in the Health and Care Act 2022, and in policy and guidance focused on place to date; it should be preserved as the integration white paper proposals and wider national reform agenda progress.
- **The government should continue to focus on practical enablers of integration**. Addressing issues such as NHS and social care workforce integration and shared data, for example, could make a real contribution to truly joined up care at place level.
- **National policy makers should have realistic expectations of place-based partnerships**. Trust leaders are optimistic and ambitious about place collaboration making a positive impact for local communities, but the operational and financial context remains challenging and places are working from different starting points. It will take time to demonstrate impact.
- **For place-based partnerships to succeed, the services that people access at place beyond those provided by trusts – adult social care, public health, primary care and the voluntary sector – need to be adequately resourced and able to recruit and retain enough staff**. The government has taken a number of steps to reform adult social care, but more action and funding is required to ensure people receive the right care at the right time in the right setting.
- **Decisions about pooling and aligning NHS and social care budgets must be taken locally**. Trust leaders are supportive of a strategic aim to make best use of collective health and care resources but remain cautious about the emphasis in the integration white paper on managing a growing proportion of health and care budgets through pooled or aligned arrangements. Trust leaders cite local government funding shortfalls as a key risk: combining budgets without addressing this underlying issue could exacerbate existing pressures on NHS budgets.
- **Place-based working will present new questions for national bodies about how they oversee quality and performance**. Trusts are supportive of a focus on shared outcomes at place but detect risks in additional layers of oversight and monitoring. There is an opportunity to strike a balance as NHS England develops its new operating model, and CQC refines its monitoring and inspection approach.
- **National policy makers must support trusts to navigate the complexities of delivering integrated care at place and collaborations at scale across wider footprints**. Trusts are involved in a myriad of collaborative arrangements, which will develop over time, and which all require good relationships, robust governance and leadership headroom. The respective roles of place-based partnerships, provider collaboratives and the integrated care board/partnership will need to be clearly defined by local partners.

8 CONCLUSION

Place is positioned in many systems, and in national policy, as a key building block within ICSs. Trusts see themselves as having important, but varied, roles to play in the partnership arrangements within those places. Their commitment to integrating health and care, and improving population health outcomes, access and experience is an important starting point. But they are also looking to go further and work with system partners to address health inequalities and the wider determinants.

It remains to be seen what the role of places will be in different systems, and how they will relate to the ICB, ICP and provider collaboratives. There are also important questions about how the funding will flow, where previous commissioning functions might be delegated, and what strategic planning responsibilities – such as for workforce or estates – will take place within the system.

As trusts and their partners continue to develop their work in local places, it will be important for the national NHS bodies to avoid implementing any 'one size fits all' approaches. For places to flourish, they need a flexible national policy framework. Every trust has a unique contribution to make at place level, and should be supported to seize this opportunity.

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