Health Education England

Evidence Brief: Place-based and integrated care systems

Contents

Produced by the HEE Knowledge Management team Evidence Briefs offer a quick overview of the published reports, research, and evidence on a workforce-related topic.

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- Complete Evidence Brief list – link for External staff

Definitions

What is place-based care?

Place-based care: A simple proposition lies at the heart of place-based care: that we blur institutional boundaries across a location to provide integrated care for individuals, families and communities. Energy, money and power shifts from institutions to citizens and communities. Devolution becomes an enabler for a reform programme that starts to deliver on the long-held promise of joining up health and social care for a population in a place, with the ultimate aim to improve the public's health and reduce health inequalities.[1]

And that there is value in:

- collaborating at different levels in the system
- building up from places and neighbourhoods
- providing leadership across the system
- focusing on functions that are best performed at scale.[2]

What are Integrated Care Systems (ICSs), Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs)?

Integrated Care Systems (ICSs): are partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas. There are 42 ICSs across England, covering populations of around 500,000 to 3 million people.[3]

Developing more joined-up health and care has been a bottom up, step-by-step journey for the NHS and its partners, building on the expertise of frontline staff and learning from what works well in different areas.[4]

On the 1st July 2022 statutory Integrated Care Systems (ICSs) arrangements were established after the passing of the Health and Care Act 2022.[5]

Statutory ICSs comprise two key components:

- **integrated care boards (ICBs):** statutory bodies that are responsible for planning and funding most NHS services in the area
- **integrated care partnerships (ICPs):** statutory committees that bring together a broad set of system partners (including local government, the voluntary, community and social enterprise sector (VCSE), NHS organisations and others) to develop a health and care strategy for the area.

Working through their ICB and ICP, ICSs have four key aims:

- improving outcomes in population health and health care
- tackling inequalities in outcomes, experience and access
- enhancing productivity and value for money

[1] The journey to place based health, UK Health Security Agency (2016)
[2] Health and wellbeing boards and integrated care systems, The King's Fund (2019)
[3] Integrated care systems explained making sense of systems, places and neighbourhoods, The King's Fund (2022)
[4] The journey to integrated care systems in every area, NHS England (2022)
[5] Health and Care Act 2022, legislation.gov.uk (2022)

- helping the NHS to support broader social and economic development. [3]

The ICB Establishment Order, list of statutory ICBs and a map of the areas covered by the 42 ICBs (and ICSs) are available on the NHS England website.[6]

The Hewitt Review

In December 2022 the Secretary of State for Health and Social Care appointed the Rt Hon Patricia Hewitt to consider the oversight and governance of integrated care systems (ICSs). The review will consider how the oversight and governance of ICSs can best enable them to succeed, balancing greater autonomy and robust accountability. Evidence gathering and consultation closed on the 9th of January 2023 with feedback to be published soon.[7]

An overview of neighbourhoods, places, and systems

- **Neighbourhoods** (covering populations of around 30,000 to 50,000 people*): where groups of GP practices work with NHS community services, social care and other providers to deliver more co-ordinated and proactive care, including through the formation of primary care networks (PCNs) and multi-agency neighbourhood teams.
- **Places** (covering populations of around 250,000 to 500,000 people*): where partnerships of health and care organisations in a town or district – including local government, NHS providers, VCSE organisations, social care providers and others – come together to join up the planning and delivery of services, redesign care pathways, engage with local communities and address health inequalities and the social and economic determinants of health. In many (but not all) cases, place footprints are based on local authority boundaries.
- **Systems** (covering populations of around 500,000 to 3 million people*): where health and care partners come together at scale to set overall system strategy, manage resources and performance, plan specialist services, and drive strategic improvements in areas such as workforce planning, digital infrastructure and estates.
- * Population sizes are variable – numbers vary from area to area and may be larger or smaller than those presented here. Systems are adapting this model to suit their local contexts, for example some larger systems have an additional intermediate tier between place and system.[3]

Other useful definitions

Place-based partnerships: Place-based partnerships are collaborative arrangements between organisations responsible for arranging and delivering health and care services and others with a role in improving health and wellbeing. They are a key building block of the integrated care systems (ICSs) recently established across England and play an important role in co-ordinating local services and driving improvements in population health. There are currently around 175 place-based partnerships in England. [8]

[6] Integrated care boards in England, NHS England (May 2022)
[7] Hewitt review: call for evidence, Department of Health and Social Care (December 2022)
[8] Place-based partnerships explained, The King's Fund (November 2022)

Anchor institutions: Anchor institutions are large, public sector organisations that are called such because they are unlikely to relocate and have a significant stake in a geographical area – they are effectively 'anchored' in their surrounding community. They have sizeable assets that can be used to support local community wealth building and development, through procurement and spending power, workforce and training, and buildings and land. Anchors have a mission to advance the welfare of the populations they serve. [9]

Primary Care Networks: Primary care networks (PCNs) form a key building block of the NHS long-term plan. Bringing general practices together to work at scale has been a policy priority for some years for a range of reasons, including improving the ability of practices to recruit and retain staff; to manage financial and estates pressures; to provide a wider range of services to patients and to more easily integrate with the wider health and care system.[10]

ICS (integrated care systems) are a way of planning and organising the delivery of health and care services in England at a larger scale than PCNs. Every ICS will have a critical role in ensuring that PCNs work with other community staff and use multi-disciplinary teams across primary and community care.[11]

Health and Wellbeing Boards (HWBs): The Health and Social Care Act 2012 introduced HWBs, which became operational on 1 April 2013 in all 152 local authorities with social care and public health responsibilities.
HWBs:

- provide a strong focus on establishing a sense of place
- instil a mechanism for joint working and improving the wellbeing of their local population
- set strategic direction to improve health and wellbeing

The Health and Care Act 2022 did not change the statutory duties of HWBs as set out by the 2012 Act but established new NHS bodies known as ICBs and required the creation of ICPs in each local system area. This will empower local health and care leaders to join up planning and provision of services, both within the NHS and with local authorities, and help deliver more person-centred and preventative care.[12]

Devolution: In England, devolution is the transfer of powers and funding from national to local government. It is important because it ensures that decisions are made closer to the local people, communities and businesses they affect.[13]

[9] Building healthier communities: the role of the NHS as an anchor institution, Health Foundation (August 2019)
[10] Primary care networks explained, The King's Fund (November 2020)
[11] Primary care networks (PCNs), British Medical Association (June 2021)
[12] Health and wellbeing boards – guidance, Department of Health and Social Care (November 2022)
[13] Devolution explained, Local Government Association

Integrated care

Reports, guides, and explainers

People, partnerships and place: how can ICSs turn the rhetoric into reality?
Source: Nuffield Trust
Publication date: 20th January 2023
Integrated care systems are now legally responsible for leading the charge on using a localised approach to bring multiple aspects of the health care system closer together, and for working better with social care and other public services. But this is far from a new aspiration - why should it be any different this time? Nuffield Trust hosted a series of roundtables to discuss concerns with stakeholders and experts and understand how to ensure the aims are achieved. This new report consolidates these findings and offers ways forward as the new era gets underway.

Accountability and autonomy in the NHS in England: priorities for the Hewitt review
Source: NHS Confederation
Publication date: 5th January 2023
Sir Chris Ham reflects on progress made against his recommendations on the conditions ICSs need to succeed and on next steps for the Hewitt review.

Hewitt review: call for evidence
Source: Department of Health and Social Care
Publication date: 13th December 2022
The Secretary of State for Health and Social Care has appointed the Rt Hon Patricia Hewitt to consider the oversight and governance of integrated care systems (ICSs). The review will consider how the oversight and governance of ICSs can best enable them to succeed, balancing greater autonomy and robust accountability. It will have a particular focus on real time data shared digitally with the Department of Health and Social Care, and on the availability and use of data across the health and care system for transparency and improvement.

Health and wellbeing boards – guidance
Source: Department of Health and Social Care
Publication date: November 2022
Health and wellbeing boards (HWBs) have been a key mechanism for driving joined up working at a local level since they were established in 2013.
The Health and Care Act 2022 introduced new architecture to the health and care system, specifically the establishment of integrated care boards (ICBs) and integrated care partnerships (ICPs).
In this new landscape, HWBs continue to play an important statutory role in instilling mechanisms for joint working across health and care organisations and setting strategic direction to improve the health and wellbeing of people locally.

Place-based partnerships explained
Author(s): Naylor and Charles
Source: The King's Fund
Publication date: 3rd November 2022
Place-based partnerships are collaborative arrangements between organisations responsible for arranging and delivering health and care services and others with a role in improving health and wellbeing. They are a key building block of the integrated care systems (ICSs) recently established across England and play an important role in co-ordinating local services and driving improvements in population health.

Integrated workforce thinking across systems: practice solutions to support Integrated Care Systems (ICSs)

Source: NHS Employers
Publication date: 19th October 2022
This guide has been written to support employers in integrated workforce thinking, in line with delivering the ICS strategy.

Introducing Integrated Care Systems: joining up local services to improve health outcomes
Source: National Audit Office
Publication date: 14th October 2022
This report examines the setup of ICSs by DHSC, NHSE, and their partners and the risks they must manage. Unlike many National Audit Office reports, this is not an assessment of whether the programme has secured good value for money to date because ICSs have only recently taken statutory form. Instead, it is an assessment of where they are starting from and the challenges and opportunities ahead. We make recommendations intended to help manage those risks and realise those opportunities.

Integrated care systems explained: making sense of systems, places and neighbourhoods
Source: The King's Fund
Publication date: Update 19th August 2022
This explainer was originally published on 9 April 2020. It was updated on 19 August 2022. What are integrated care systems? Integrated care systems (ICSs) are partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas. There are 42 ICSs across England, covering populations of around 500,000 to 3 million people.

Realising the benefits of provider collaboratives
Source: NHS Providers
Publication date: August 2022

- Trust leaders see significant opportunities in working collaboratively to benefit patients and service users. They know that no single organisation can tackle the systemic challenges facing the health and care sector alone and want to build on the success of collaboration during the COVID-19 response to deliver high quality, joined up and more efficient care for local communities.
- Trusts and their system partners have been developing these collaborative ways of working for several years. However, national policy has only recently formalised them in the Health and Care Act 2022 and guidance, including on provider collaboratives and place-based partnerships.

A guide to the Health and Care Act
Source: NHS Providers
Publication date: July 2022
The Health and Care Act 2022 (the Act) contains the biggest reforms to the NHS in nearly a decade, laying the foundations to improve health outcomes by joining up NHS, social care and public health services at a local level and tackling growing health inequalities. The majority of the Act is focused on developing system working with integrated care systems (ICSs) being put on a statutory footing through the creation of integrated care boards (ICBs). It also moves the NHS away from competitive retendering by default and towards collaborative delivery.

Health and Care Act 2022
Source: Legislation.gov.uk
Publication date: July 2022

The journey to integrated care systems in every area
Source: NHS England

Developing more joined-up health and care has been a bottom up, step-by-step journey for the NHS and its partners, building on the expertise of frontline staff and learning from what works well in different areas.

Integrated Care Systems: getting the right workforce development support to ICSs
Source: Skills for Care; Health Education England
Publication date: July 2022
Skills for Care and HEE have been working together over the past few months on an offer to help support ICSs to look at workforce, building on learning from existing local initiatives at system and place level. We recognise that a lot of successful integration projects start with strategic relationships, agreeing priorities and identifying enablers which leads to project delivery. All the initiatives set out in the offer are already happening somewhere, thanks to collaboration between ICSs and the regional teams in Skills for Care and HEE. There are many examples of how we've worked effectively together across ICS footprints, particularly on workforce projects with employer engagement, joint consultation and funding, resulting in lots of potential for positive impact and enhanced relationships. Our offer is underpinned by generous, inclusive leadership and it is important to recognise how far some ICSs and their local authority partners have already taken an integration agenda.

Integrated care systems: what do they look like?
Source: Health Foundation
Publication date: 15th June 2022

- Integrated care systems (ICSs) are the centrepiece of the biggest legislative overhaul of the NHS in a decade. From July 2022, England will be formally divided into 42 area-based ICSs, covering populations of around 500,000 to 3 million people.
- ICSs face a mammoth task. Staffing shortages in the NHS are chronic, health and care services are under extreme strain, and health inequalities are wide and growing. This long read presents analysis of publicly available data on some of the characteristics of ICSs and policy context in each area. We outline some of the challenges facing ICSs and reflect on the implications for national policy.
- The task facing ICSs is not equal. Pressures on services and the health of the population vary widely between ICSs – as do the resources available to address them. ICSs also look very different in their size, complexity and other characteristics that will shape how they function and their ability to collaborate to improve services.
- National policy on ICSs must acknowledge this variation and be realistic about what different areas can achieve. Differences in local context should be reflected in how ICS performance is assessed and reported. Policymakers must target support for ICSs with different needs, and some areas will likely require additional resources to help deliver national policy objectives.

What are Integrated Care Systems?
Source: NHS Confederation
Publication date: June 2022
The Health and Care Act was passed in April 2022. The legislation puts Integrated Care Systems (ICS) – which have existed in shadow form for a number of years – on a statutory footing from 1st July 2022, meaning they are now responsible for planning and funding health and care services in the area they cover. They are a core part of the NHS Long Term Plan from 2019 and build on how services have been working together already at local levels to orientate health and care much more around the people they serve rather than their

organisational boundaries. Their establishment represents the first large-scale structural change to the NHS since 2012.

Integrated care systems: how will they work under the Health and Care Act?
Source: The King's Fund
Publication date: May 2022
Integrated care systems (ICSs) are geographically based partnerships that bring together providers and commissioners of NHS services with local authorities and other local partners to plan, co-ordinate and commission health and care services. They are part of a fundamental shift in the way the health and care system is organised – away from competition and organisational autonomy and towards collaboration, with health and care organisations working together to integrate services and improve population health. ICSs have been developing for several years – since July 2022 the Health and Care Act has put them on a statutory footing.

Integrated care boards in England
Source: NHS England
Publication date: May 2022
Information about integrated care boards (ICBs): the Establishment Order for ICBs, a table setting out the statutory list of ICBs, a map of the areas covered by the 42 ICBs (and ICSs) and the ICB constitutions.

Next steps for integrating primary care: Fuller stocktake report
Source: NHS England
Publication date: May 2022
This is the final report of the stocktake undertaken by Dr Claire Fuller, Chief Executive-designate Surrey Heartlands Integrated Care System and GP on integrated primary care, looking at what is working well, why it's working well and how we can accelerate the implementation of integrated primary care (incorporating the current 4 pillars of general practice, community pharmacy, dentistry and optometry) across systems.

Devolve to evolve? The future of specialised services within integrated care
Source: Policy Exchange
Publication date: May 2022
Specialised services typically care for small numbers of patients with rare or complex conditions. They are commonly overlooked in debates around the future of the NHS. This is despite costs growing by over 50% in eight years, and now exceeding £20bn per year. This one part of the NHS now receives more taxpayer funding than providing police services and fighting crime.

Clinical commissioning groups: transferring the legacy into learning
Source: NHS Confederation
Publication date: 3rd March 2022
Reflections and recommendations from clinical commissioning groups to help inform the success of integrated care systems.

Joining up care for people, places and populations
Source: Department of Health and Social Care
Publication date: February 2022
This white paper sets out measures to make integrated health and social care a universal reality for everyone across England regardless of their condition and of where they live.
"Successful integration is the planning, commissioning and delivery of co-ordinated, joined up and seamless services to support people to live healthy, independent and dignified lives and which improves outcomes for the population as a whole. Everyone should receive the right care, in the right place, at the right time."

Developing and leading ICSs – GGI and Coventry University
Source: Good Governance Institute
Publication date: 28th January 2022
This short briefing paper summarises the key discussion points that arose from a panel discussion hosted by GGI and Coventry University on 17 November 2021.
The event focused on the leadership and workforce challenges associated with the development of Integrated Care Systems (ICSs) with three seminal speakers framing the conversation for a live audience.

Local health systems: relationships not structures
Source: Local Government Information Unit (LGiU)
Authors: Walker, D.A., Sillett, J. and Hussain, F.
Publication Date: 2022
Explores the role of local government, and ways of effective working, within local systems for health and wellbeing, drawing on qualitative research in three areas of England. Outlines the statutory responsibilities of local authorities which influence health and wellbeing, and summarises the key recommendations arising from the study. Describes the concept of systems thinking in looking at local health and care systems and partnership working. Presents the findings of research in the three local authority areas, highlighting the importance of relationships rather than structures and identifying the barriers to a more strategic systems focus within the public sector. Discusses the recent policy history of local health integration, including legislation, NHS strategic plans, place-based partnerships and the 2021 adult social care reform white paper. Presents conclusions, and case studies looking at the London Borough of Brent and Neath Port Talbot County Borough Council.

Putting patients first: how integrated care systems can drive better outcomes.
Source: Reform
Publication Date: 2021
This event write-up brings together ideas generated at a Reform and Social Enterprise policy roundtable in late November 2021. It is a high-level summary of the key themes raised none-of-which are attributable to either speaker or any attendee. The discussion was introduced by Mark Cubbon, the interim Chief Operating Officer of NHS England, and Professor Jo Pritchard OBE, Director of Health and Social Care at Social Enterprise UK. The write-up covers the following key areas: the importance of integration; putting patients first; towards subsidarity; a place-based approach; opportunities for innovation; relationship-led change; and a vision for the future of care.

Integrated care explained
Source: Nuffield Trust
Publication date: 13th December 2021
Each of the four countries in the UK has a long-standing goal to integrate health and social care services. But what exactly do we mean by that? This explainer answers important questions on what integrated care is, how it's changed, and whether it works. There are also links to our current and past work on the subject.

Integrated care systems: guidance
Source: NHS England
Publication date: June 2021 (updated December 2022)
These documents set out the headlines for how we will ask NHS leaders and organisations to operate with their partners in integrated care systems from July 2022 and guidance in respect of what the employment commitment is, its application in practice and how it affects people.

- Integrated care strategy guidance
- Expected ways of working between integrated care partnerships and adult social care providers.
- Guidance to integrated care boards on applying to NHS England to amend their constitution
- Guidance on the preparation of integrated care board constitutions
- Guidance on the preparation of integrated care board constitutions - annex
- Thriving places: guidance on the development of place-based partnerships as part of statutory integrated care systems
- Integrated care system implementation guidance on working with people and communities
- Integrated care system implementation guidance on effective clinical and care professional leadership
- Integrated care system implementation guidance on partnerships with the voluntary, community and social enterprise sector
- Human resources framework for developing integrated care boards
- Building strong integrated care systems everywhere: guidance on the integrated care system people function
- Working together at scale: guidance on provider collaboratives
- Integrated care systems: design framework
- Guidance on the employment commitment: supporting the development and transition towards statutory integrated care systems

The relationship between the adult social care sector and ICSs: time for action?
Source: Good Governance Institute
Author: SMITH, C.
Publication Date: 2021
Abstract: This short paper brings together our thinking around some of the key pieces of policy pertaining to the adult social care sector, as well as the learning from a series of interviews and a roundtable with ICS independent chairs, policy-makers and adult social care providers. Where relevant, we also present example of good practice from across the country. Historically, adult social care services have not been engaged as effectively as they might have been in system planning initiatives such as STPs and ICSs. Our 2017 report 'System transformation and care homes' revealed the limited extent to which STPs had involved or reflected upon the adult social care sector in their plans. While progress has been made since, in researching this report we heard, anecdotally, that there is a mixed picture across the country and that there remains much to do for adult social care to be accepted on an equal basis with health. On the one hand, we have seen sustained progress towards partnership working both at a system level and a place level, as well as increasing use of technology and innovation to help mitigate many of the challenges that the social care sector faces. On the other hand, workforce pressures have increased significantly and the sector remains precariously placed financially. In order for progress to be maintained and built upon, we recommend that: the NHS and ICS' engage effectively with adult social care and the independent care sector; we recognise that Covid-19 has forced closer working across systems which needs to be embedded in future working; the shared workforce challenges across health and social care are addressed collectively; the crucial role that the sector has in local economies and place-based health through employment is acknowledged and supported; upcoming legislative changes

reduce the complexity within the system to enable care sector organisations to engage as effectively as possible.

Developing place-based partnerships: the foundation of effective integrated care systems
Source: The King's Fund
Publication date: April 2021
Integrated care systems (ICSs) now cover all areas of the country and will soon be established as statutory bodies with major responsibilities for NHS planning and funding. But most of the heavy lifting involved in integrating care and improving population health will happen more locally in the places where people live, work and access services, meaning place-based partnerships within ICSs will play a key role in driving forward change. These will need to involve a wide range of partners to act on the full range of factors that influence health and wellbeing.

The role of primary care in integrated care systems
Source: NHS Confederation
Publication date: 2021
This report sets out the views of our primary care members on the underpinning principles needed for strong primary care involvement at system and place.

Integrated care systems explained: making sense of the new NHS structure.
Source: NHS Providers
Authors: Butterworth, Georgia;Al-haboubi, Yasmin and NHS Providers
Publication Date: 2021
Delivering more joined-up care for patients has been a key ambition for the NHS over the past few years. This glossary was developed following NHS Providers' recent virtual workshops, where governors expressed a desire to learn more about the acronyms and terminology that are now commonly used to describe how the NHS structure is evolving.

Primary care networks explained
Author(s): Baird and Beech
Source: The King's Fund
Publication date: November 2020
A key part of the NHS long-term plan, primary care networks (PCNs) will bring general practices together to work at scale. But what are they? How are they funded and held accountable? And what difference will they make? Beccy Baird explains the latest form of GP collaboration.

Growing our own future: a manifesto for defining the role of integrated care systems in workforce, people and skills
Source: NHS Confederation
Publication Date: 2020
This manifesto sets out what the new operating model for workforce development in health and care, promised in the Interim NHS People Plan, should focus on. The recommendations are necessary to realise the potential of integrated care systems and have the support of local leaders.

From place-based to place-led: a whole-area approach to integrating care systems.
Source: NHS Confederation. Integrated Care Systems Network
Item Type: Journal Article
Publication Date: 2020
This paper describes the essential role of place-based approaches in taking forward the NHS reform agenda. Based on interviews with senior leaders, it seeks to provide further insight into how local systems can make progress in designing and delivering place-based, integrated care. In particular, it describes what system leaders can do to make this happen.

Levelling up Yorkshire and Humber: health as the new wealth post-COVID
Source: NHS Confederation
Author: Nhs Confederation, Yorkshire and Huer Academic Health Science Network and Yorkshire Universities
Publication Date: 2020
This report provides a plan to tackle ever-increasing socio-economic inequalities and boost health outcomes in Yorkshire and the Humber by encouraging and supporting more cross-sector working. Leaders and clinicians across the NHS and social care have called for a 'reset' to the way health and care are planned, commissioned and delivered, building on the rapid progress already made during the COVID-19 pandemic. The paper argues that the recovery approach must recognise that health and the economy are bound tightly together. Interventions designed to improve health, inclusive growth and wellbeing are in the interests of all local, regional and national partners, businesses and communities and should be a shared priority and endeavour. Businesses and anchor institutions must adopt a stronger health-led and inclusive economic growth agenda, bolstered by increased 'place-sensitive' policy and strategy from government and national agencies. There is a role for place-based partnerships across the region - including Integrated Care Systems, Local Enterprise Partnerships and Combined Authorities - to help unlock even more local potential and achieve improved health and inclusive growth for Yorkshire and the Humber.

Health and wellbeing boards and integrated care systems
Author(s): Richard Humphries
Source: The King's Fund
Publication date: 13th November 2019
Health and wellbeing boards (HWBs) were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population.

The NHS Long Term Plan
Source: NHS
Publication date: January 2019
The NHS Long Term Plan was developed in partnership with those who know the NHS best – frontline health and care staff, patients and their families and other experts.
See 1.9 Primary care networks of local GP practices and community teams "The £4.5 billion of new investment will fund expanded community multidisciplinary teams aligned with new primary care networks based on neighbouring GP practices"
See 3.94 "new and integrated models of primary and community mental health care support adults and older adults with severe mental illnesses […] local areas will be supported to redesign and reorganise core community mental health teams to move towards a new place-based, multidisciplinary service across health and social care aligned with primary care networks"
See 7.14 "remove specific impediments to 'place-based' NHS commissioning"
See Appendix p. 120 The NHS as an 'anchor institution' - "As an employer of 1.4 million people, with an annual budget of £114 billion in 2018/19, the health service creates social value in local communities"

Developing healthier places: how councils can work with developers to create places that support wellbeing
Source: Local Government Association
Publication date: 2018
The information in this guide has been drawn from 10 workshops, and other events, held across England in 2017. In the last few years there has been a reawakening of awareness that the built environment has a profound effect on whether or

not people live healthy lives. Put simply, the places in which we live shape the way we live. People who live in neighbourhoods with clean air, good parks, streets that are easy and pleasant to walk and cycle along, places to meet and socialise, jobs and opportunities, find it easier to live healthy fulfilling lives than those who are not so lucky.

Shifting the centre of gravity: making place-based person-centred health and care a reality
Source: Local Government Association
Publication date: 2018
This report sets out a vision for transforming health, care and wellbeing and outlines key actions that organisations should take to successfully integrate health and care. It also includes an integration checklist which can be used to assess progress. The report builds on the vision set out in the 2016 report, 'Stepping up to the place', and aims to provide a vision for a community-based preventative service which supports people to stay healthy and independent for as long as possible. The four elements forming the basis for the vision are outlined as: individuals using health and care services experience positive outcomes; individuals, populations and communities maximise their health and wellbeing; front-line staff use their experience and expertise to shape seamless care; and leaders work effectively across health and care to drive transformation.

Journal articles

Integrated care systems face challenges fulfilling hopes of better services, says watchdog
Author(s): Matthew Limb
Source: BMJ 379
Publication date: October 2022
New integrated care systems (ICSs) in England will struggle to deliver long term improvements in people's health amid "extreme" funding and staffing pressures in the NHS and social care, the public spending watchdog has warned.
The National Audit Office said in a report1 that for the local care systems to succeed, ministers must tackle workforce shortages, ensure sustainable NHS finances, and coordinate measures across government to tackle wider determinants of ill health.

The move towards integrated care: Lessons learnt from managing patients with multiple morbidities in the UK
Author(s): Litchfield et al.
Source: Health Policy 126(8)
Publication date: August 2022
Introduction: The multi-disciplinary care offered to patients with multi-morbidities offers a powerful example of the practical challenges faced by the National Health Service's planned move to more closely integrated models of care. Purpose, objective, and contributions: The intention of this work was to identify the opportunities and obstacles presented by the current provision of integrated care and explore their implications for existing and future policy initiatives. Materials and Methods: We conducted a qualitative exploration of the experiences of senior managers, commissioners and clinicians, using a post-hoc content analysis to populate and present the results within the multi-componential Sustainable integrated chronic care model for multi-morbidity: delivery, financing, and performance (SELFIE) framework designed to understand integrated care. Results: A total of 13 senior medical directors, commissioners, and managers, and 15 clinicians from a range of care settings were interviewed. Relative factors within the six framework components were identified namely; issues around communication between settings (Service delivery), the importance of collaborative leadership (Leadership & governance); the need for high-level collaboration (Workforce), better directed financial incentives (Financing), the lack of software interoperability (Technologies and medical

products) and constraints on sharing and utilising patient data (Information & Research). Conclusions: The SELFIE framework has provided valuable insight into the challenges presented by inter-organisational and inter-professional working that will help guide the design and implementation of policies promoting integrated care. These may be mitigated by sharing the varied experiences and priorities that exist across primary and care settings, alongside improving communication and supporting collaborative leadership. There also appears a clear role for refocussing financial incentives to reward shared responsibility at all levels of service delivery.

United Kingdom: Health System Review
Item Type: Journal Article
Authors: Anderson, Michael;Pitchforth, Emma;Edwards, Nigel;Alderwick, Hugh;McGuire, Alistair and Mossialos, Elias
Publication Date: May ,2022
Journal: Health Systems in Transition 24(1), pp. 1-194
Abstract: This analysis provides a review of developments in financing, governance, organisation and delivery, health reforms and performance of the health systems in the United Kingdom. The United Kingdom has enjoyed a national health service with access based on clinical need, and not ability to pay for over 70 years. This has provided several important benefits including protection against the financial consequences of ill-health, redistribution of wealth from rich to poor, and relatively low administrative costs. Despite this, the United Kingdom continues to lag behind many other comparable high-income countries in key measures including life expectancy, infant mortality and cancer survival. Total health spending in the United Kingdom is slightly above the average for Europe, but it is below many other comparable high-income countries such as Germany, France and Canada. The United Kingdom also has relatively lower levels of doctors, nurses, hospital beds and equipment than many other comparable high-income countries. Wider social determinants of health also contribute to poor outcomes, and the United Kingdom has one of the highest levels of income inequality in Europe. Devolution of responsibility for health care services since the late 1990s to Scotland, Wales and Northern Ireland has resulted in divergence in policies between countries, including in prescription charges, and eligibility for publicly funded social care services. However, more commonalities than differences remain between these health care systems. The United Kingdom initially experienced one of the highest death rates associated with COVID-19; however, the success and speed of the United Kingdom's vaccination programme has since improved the United Kingdom's performance in this respect. Principal health reforms in each country are focusing on facilitating cross-sectoral partnerships and promoting integration of services in a manner that improves the health and well-being of local populations. These include the establishment of integrated care systems in England, integrated joint boards in Scotland, regional partnership boards in Wales and integrated partnership boards in Northern Ireland. Policies are also being developed to align the social care funding model closer to the National Health Service funding model. These include a cap on costs over an individual's lifetime in England, and a national care service free at the point of need in Scotland and Wales. Currently, and for the future, significant investment is needed to address major challenges including a growing backlog of elective care, and staffing shortfalls exacerbated by Brexit.

A picture of health: determining the core population served by an urban NHS hospital trust and understanding the key health needs.
Item Type: Journal Article

Authors: Beaney, Thomas;Clarke, Jonathan M.;Grundy, Emily and Coronini-Cronberg, Sophie
Publication Date: 01 12 ,2022
Journal: BMC Public Health 22(1), pp. 75
Abstract: BACKGROUND: NHS hospitals do not have clearly defined geographic populations to whom they provide care, with patients able to attend any hospital. Identifying a core population for a hospital trust, particularly those in urban areas where there are multiple providers and high population churn, is essential to understanding local key health needs especially given the move to integrated care systems. This can enable effective planning and delivery of preventive interventions and community engagement, rather than simply treating those presenting to services. In this article we describe a practical method for identifying a hospital's catchment population based on where potential patients are most likely to reside, and describe that population's size, demographic and social profile, and the key health needs. METHODS: A 30% proportional flow method was used to identify a catchment population using an acute hospital trust in West London as an example. Records of all hospital attendances between 1st April 2017 and 31st March 2018 were analysed using Hospital Episode Statistics. Any Lower Layer Super Output Areas where 30% or more of residents who attended any hospital for care did so at the example trust were assigned to the catchment area. Publicly available local and national datasets were then applied to identify and describe the population's key health needs. RESULTS: A catchment comprising 617,709 people, of an equal gender-split (50.4% male) and predominantly working age (15 to 64 years) population was identified. Thirty nine point six percent of residents identified as being from Black and Minority Ethnic (BAME) groups, a similar proportion that reported being born abroad, with over 85 languages spoken. Health indicators were estimated, including: a healthy life expectancy difference of over twenty years; bowel cancer screening coverage of 48.8%; chlamydia diagnosis rates of 2,136 per 100,000; prevalence of visible dental decay among five-year-olds of 27.9%. CONCLUSIONS: We define a blueprint by which a catchment can be defined for a hospital trust and demonstrate the value a hospital-view of the local population could provide in understanding local health needs and enabling population-level health improvement interventions. While an individual approach allows tailoring to local context and need, there could be an efficiency saving were such public health information made routinely and regularly available for every NHS hospital. Copyright © 2021. The Author(s).

Comparing registered and resident populations in Primary Care Networks in England: an observational study.
Item Type: Journal Article
Authors: Beaney, Thomas;Kerr, Gabriele;Hayhoe, Benedict Wj;Majeed, Azeem and Clarke, Jonathan
Publication Date: Dec ,2022
Journal: Bjgp Open 6(4)
Abstract: BACKGROUND: Primary Care Networks (PCNs) were established in England in 2019 and will play a key role in providing care at a neighbourhood level within integrated care systems (ICSs). AIM: To identify PCN 'catchment' areas and compare the overlap between registered and resident populations of PCNs. DESIGN & SETTING: Observational study using publicly available data on the number of people within each Lower layer Super Output Area (LSOA) registered to each general practice in England in April 2021. METHOD: LSOAs were assigned to the PCN to which the majority of residents were registered. The PCN catchment population was defined as the total number of people resident in all LSOAs assigned to that PCN. The PCN catchment populations were compared with the population of people registered to a GP practice in each PCN. RESULTS: In April 2021, 6506 GP practices were part of 1251 PCNs, with 56.1% of PCNs having

30 000-50 000 registered patients. There was a strong correlation (0.91) between the total registered population size and catchment population size. Significant variation was found in the percentage of residents in each LSOA registered to a GP practice within the same PCN catchment, and strong associations were found with both urban and rural status, and socioeconomic deprivation. CONCLUSION: There exists significant variation across England in the overlap between registered and resident (catchment) populations in PCNs, which may impact on integration of care in some areas. There was less overlap in urban and more deprived areas, which could exacerbate existing health inequalities. Copyright © 2022, The Authors.

Identifying and understanding the factors that influence the functioning of integrated healthcare systems in the NHS: a systematic literature review.
Item Type: Journal Article
Authors: Bhat, Karthik;Easwarathasan, Rokshan;Jacob, Milan;Poole, William;Sapaetharan, Vithullan;Sidhu, Manu and Thomas, Ashvin
Publication Date: 04 05 ,2022
Journal: BMJ Open 12(4), pp. e049296
Abstract: OBJECTIVES: The National Health Service has been moving towards integrated care for the best part of two decades to address the growing financial and service pressures created by an ageing population. Integrated healthcare systems (IHSs) join up health and social care services and have been established to manage the care of individuals with complex chronic conditions but with varied success. It is therefore imperative to conduct a Systematic Literature Review (SLR) to identify and understand the factors that influence their successful functioning, and ascertain the factor with the greatest influence, in order to ensure positive outcomes when establishing future IHSs. METHODS: Articles published between 1 January 1997 and 8 March 2020 were analysed from the following six databases: Healthcare Management Information Consortium, Nuffield Trust, Cumulative Index to Nursing and Allied Health Literature, PubMed, National Institute for Health and Care Excellence Evidence and Health Systems Evidence. Those deemed relevant after title and abstract screening were procured for subsequent review of the full-text article. RESULTS: Thirty-three finalised articles were analysed in this SLR to provide a comprehensive overview of the factors that influence the functioning of IHSs. Factors were stratified into six key categories: organisational culture, workforce management, interorganisational collaboration, leadership ability of staff, economic factors and political factors. Leadership was deemed to be the most influential factor due to its intrinsic and instrumental role in influencing the other key factors. CONCLUSIONS: The findings of this SLR may serve as a guide to developing tailor-made recommendations and policies that address the identified key factors and thereby improve the functioning of present and future IHSs. Furthermore, due to both its overarching influence and the inadequacy of literature in this field, there is a strong case for further research exploring leadership development specifically for IHSs. Copyright © Author(s) (or their employer(s)) 2022. Re-use permitted under CC BY-NC. No commercial re-use. See rights and permissions. Published by BMJ.

Exploring lessons from Covid-19 for the role of the voluntary sector in integrated care systems.
Item Type: Journal Article
Authors: Carpenter, Juliet;Spencer, Ben;Moreira da Souza, Tatiana;Cho, Youngha and Brett, Jo
Publication Date: Nov ,2022
Journal: Health & Social Care in the Community 30(6), pp. e6689-e6698

Abstract: Integrated care systems (ICS) in England are partnerships between different health and social care organisations, to co-ordinate care and therefore provide more effective health and social care provision. The objective of this article is to explore the role of the 'Voluntary, Community and Social Enterprise' (VCSE) sector in integrated care systems. In particular, the paper aims to examine recent experiences of the voluntary sector in responding to the Covid-19 pandemic, and the lessons that can be learnt for integrated care provision. The article focuses on the case of Oxfordshire (UK), using a mixed methods approach that included a series of semi-structured interviews with key informants in health and the VCSE sector as well as online surveys of GPs and organisations in the VCSE sector. These were complemented by two contrasting geographical case studies of community responses to Covid-19 (one urban, one rural). Data were collected between April and June 2021. Interviewees were recruited through professional and community networks and snowball sampling, with a total of 30 semi-structured interviews being completed. Survey participants were recruited through sector-specific networks and the research arm of doctors.net.uk, with a total of 57 survey respondents in all. The research demonstrated the critical role of social prescribing link workers and locality officers in forging connections between the health and VCSE sectors at the hyper-local level, particularly in the urban case study. In the rural case study, the potential role of the Parish Council in bringing the two sectors together was highlighted, to support community health and well-being through stronger integrated working between the two sectors. The article concludes that enhanced connections between health and the VCSE sector will strengthen the outcomes of ICS. Copyright © 2022 The Authors. Health and Social Care in the Community published by John Wiley & Sons Ltd.

The forgotten dimension of integrated care: barriers to implementing integrated clinical care in English NHS hospitals.
Item Type: Journal Article
Authors: Castelli, Michele;Erskine, Jonathan;Hunter, David and Hungin, Amritpal
Publication Date: 2022
Journal: Health Economics, Policy, & Law
Abstract: Multimorbid patients who enter English NHS hospitals are frequently subject to care pathways designed to assess, diagnose and treat single medical conditions. Opportunities are thereby lost to offer patients more holistic, person-centred care. Hospital organisations elsewhere are known to use in-hospital, multi-specialty, integrated clinical care (ICC) to overcome this problem. This perspective piece aims to critically discuss barriers to implementing this form of ICC in the English NHS focusing on six key areas: information technologies, the primary-secondary care interface, internal hospital processes, finance, workload, professional roles and behaviours. Integrated care programmes currently underway are largely focused on macro (system) and meso (organisational) levels. A micro (clinical) level ICC, offering highly coordinated multispecialty expertise to multimorbid hospital patients could fill an important gap in the current care pathways.

Commissioning [Integrated] Care in England: An Analysis of the Current Decision Context.
Item Type: Journal Article
Authors: Gongora-Salazar, Pamela;Glogowska, Margaret;Fitzpatrick, Ray;Perera, Rafael and Tsiachristas, Apostolos
Publication Date: 2022
Journal: International Journal of Integrated Care [Electronic Resource] 22(4), pp. 3
Abstract: Background: The emergence of Integrated Care Systems (ICSs) across England poses an additional challenge

and responsibility for local commissioners to accelerate the implementation of integrated care programmes and improve the overall efficiency across the system. To do this, ICS healthcare commissioners could learn from the experience of the former local commissioning structures and identify areas of improvement in the commissioning process. This study describes the investment decision process in integrated care amid the transition toward ICSs, highlights challenges, and provides recommendations to inform ICSs in their healthcare commissioning role. Methods: Twenty-six semi-structured interviews were conducted with local commissioners and other relevant stakeholders in South East England in 2021. Interviews were supplemented with literature. Results: England's local healthcare commissioning has made the transition towards a new organisational architecture, with some integrated care programmes running, and a dual top-down and bottom-up prioritisation process in place. The commissioning and consequent development of integrated care programmes have been hindered by various barriers, including difficulties in accessing and using information, operational challenges, and resource constraints. Investment decisions have mainly been driven by national directives and budget considerations, with a mixture of subjective and objective approaches. A systematic and data-driven framework could replace this ad-hoc prioritisation of integrated care and contribute to a more rational and transparent commissioning process. Conclusion: The emerging ICSs seem to open an opportunity for local commissioners to strengthen the commissioning process of integrated care with evidence-based priority-setting approaches similar to the well-established health technology assessment framework at the national level. Copyright: © 2022 The Author(s).

Developing programme theories of leadership for integrated health and social care teams and systems: a realist synthesis
Item Type: Journal Article
Authors: Harris, Ruth;Fletcher, Simon;Sims, Sarah;Ross, Fiona;Brearley, Sally and Manthorpe, Jill
Publication Date: 2022
Journal: NIHR Journals Library
Abstract: BACKGROUND: As the organisation of health and social care in England moves rapidly towards greater integration, the resulting systems and teams will require distinctive leadership. However, little is known about how the effective leadership of these teams and systems can be supported and improved. In particular, there is relatively little understanding of how effective leadership across integrated care teams and systems may be enacted, the contexts in which this might take place and the subsequent implications this has on integrated care. OBJECTIVE: This realist review developed and refined programme theories of leadership of integrated health and social care teams and systems, exploring what works, for whom and in what circumstances. DESIGN: The review utilised a realist synthesis approach, informed by the Realist And Meta-narrative Evidence Syntheses: Evolving Standards (RAMESES) publication standards, to explore existing literature on the leadership of integrated care teams and systems, complemented by ongoing stakeholder consultation. Empirical evidence specifically addressing leadership of integrated teams or services was limited, with only 36 papers included in the review. The evidence collected from these 36 papers was synthesised to identify and build a comprehensive description of the mechanisms of leadership of integrated teams and systems and their associated contexts and outcomes. Consultation with key stakeholders with a range of expertise throughout the process ensured that the review remained grounded in the reality of health and social care delivery and addressed practice and policy challenges.

RESULTS: Evidence was identified for seven potentially important components of leadership in integrated care teams and systems. These were 'inspiring intent to work together', 'creating the conditions to work together', 'balancing multiple perspectives', 'working with power', 'taking a wider view', 'a commitment to learning and development' and 'clarifying complexity'. No empirical evidence was found for an eighth mechanism, 'fostering resilience', although stakeholders felt that this was potentially an important, long-term component of leadership. A key message of the review was that empirical research often focused on the importance of who the leader of an integrated team or service was (i.e. their personality traits and characteristics) rather than what they did (i.e. the specific role that they played in integrated working), although stakeholders considered that a focus on leader personality was not sufficient. Other key messages highlighted the way in which power and influence are used by integrated service leaders and identified the hierarchies between health and social care which complicate the leading of integrated teams and systems. LIMITATIONS: Evidence specifically addressing leadership of integrated care teams and systems was limited and lacking in detail, which restricted the degree to which definitive conclusions could be drawn around what works, for whom and in what circumstances. CONCLUSIONS: Research into the leadership of integrated care teams and systems is limited and underdeveloped, with ideas often reverting to existing framings of leadership in which teams and organisations are less complex. In making explicit some of the assumptions about how leaders lead integrated care teams and systems this review has contributed significant new perspectives, offering fresh theoretical grounding that can be built on, developed and tested further. FUTURE WORK: By making explicit some of the assumptions underlying the leadership of integrated care teams and systems, this review has generated new perspectives that can be built on, developed and tested further. STUDY REGISTRATION: This study is registered as PROSPERO CRD42018119291. FUNDING: This project was funded by the National Institute for Health Research (NIHR) Health and Social Care Delivery Research programme and will be published in full in Health and Social Care Delivery Research; Vol. 10, No. 7. See the NIHR Journals Library website for further project information.

An integrated care model for mental health in diabetes: Recommendations for local implementation by the Diabetes and Mental Health Expert Working Group in England.
Item Type: Journal Article
Authors: Sachar, Amrit;Breslin, Niki and Ng, Sze May
Publication Date: Dec 20 ,2022
Journal: Diabetic Medicine e15029
Abstract: CONTEXT: In 2019, NHS England and Diabetes UK convened an Expert Working Group (EWG) in order to develop a Model and recommendations to guide commissioning and provision of mental health care in diabetes pathways and diabetes care in mental health pathways. The recommendations are based on a combination of evidence, national guidance, case studies and expert opinion from across the UK and form other long term conditions. THE CASE FOR INTEGRATION: There is good the evidence around the high

prevalence of co-morbidity between diabetes and mental illness of all severities and, the poorer diabetes and mental health outcomes for patients when this co-morbidity exists. Detecting and managing the mental health co-morbidity improves these outcomes, but the evidence suggests that detection of mental illness is poor in the context of diabetes care in community and acute care settings and that when it is detected, the access to appropriate mental health resource is variable and generally inadequate. THE MODEL OF INTEGRATED CARE FOR DIABETES: The EWG developed a one-page Model with five core principles and five operational work-streams to support the delivery of integration, with examples of local case studies for local implementation. The five core principals are: Care for all-describing how care for all PWD needs to explore what matters to them and that emotional wellbeing is supported at diagnosis and beyond; Support and information-describing how HCPs should appropriately signpost to mental health support and the need for structured education programmes to include mental healthcare information; Needs identified-describing how PWD should have their mental health needs identified and acted on; Integrated care-describing how people with mental illness and diabetes should have their diabetes considered within their mental health care; Specialist care-describing how PWD should be able to access specialist diabetes mental health professionals. The five cross cutting work-streams for operationalising the principles are: Implementing training and upskilling of HCPs; Embedding mental health screening and assessment into diabetes pathways; Ensuring access to clear, integrated local pathways; Ensuring addressing health inequalities is incorporated at every stage of service development; Improving access to specialist mental health services through commissioning. DISCUSSION AND CONCLUSIONS: The Model can be implemented in part or completely, at an individual level, all the way up to system level. It can be adapted across the life span and the UK, and having learnt from other long term conditions, there is a lot of transferability across all long term conditions There is an opportunity for ICBs to consider economies of scale across multiple long term conditions for which there will be a significant overlap of patients within the local population. Any local implementation should be in co-production with experts by experience and third sector providers. Copyright © 2022 Diabetes UK.

An integrated care systems model approach for speech and language therapy head and neck cancer services in England: service development and re-design in Cheshire and Merseyside
Abstract only*
Item Type: Journal Article
Authors: Sheldrick, Heulwen;Houghton, Lisa;Fleming, Catriona and Crane, Julie
Publication Date: Jun 01 ,2022
Journal: Current Opinion in Otolaryngology & Head & Neck Surgery 30(3), pp. 177-181
Abstract: PURPOSE OF REVIEW: The incidence of head and neck cancer (HNC) is increasing globally and changes in treatment mean that patients are living longer with the condition. It is recognised that while there have been improvements at the diagnostic phase of the pathway, follow-up and on-going care can be fragmented and inequitable. Integrated care models (ICMs) are acknowledged as beneficial. The National Health Service in England is moving to a model whereby services are being re-organised to integrated care systems. This paper reviews the literature and discusses potential models of care to enhance speech and language therapy (SLT) provision for patients with HNC in line with the emerging ICS. RECENT FINDINGS: The COVID-19 pandemic has provided an opportunity to review service provision and SLT teams quickly adapted to offering remote support. Discussions are currently on-going to explore the potential for

patient initiated follow-up via the PETNECK 2 trial and the Buurtzorg 'neighbourhood model' holds promise. SUMMARY: ICMs put the patient at the centre of care and have reported benefits for experience of care and clinical outcomes. Navigating organisational structures is complex. The Buurtzorg model provides a practical and theoretical framework to support organisational change. Copyright © 2022 Wolters Kluwer Health, Inc. All rights reserved.

Impact of COVID-19 on social prescribing across an Integrated Care System: A Researcher in Residence study.
Item Type: Journal Article
Authors: Westlake, Debra;Elston, Julian;Gude, Alex;Gradinger, Felix;Husk, Kerryn and Asthana, Sheena
Publication Date: Nov ,2022
Journal: Health & Social Care in the Community 30(6), pp. e4086-e4094
Abstract: Emerging evidence suggests that connecting people to non-medical activities in the community (social prescribing) may relieve pressure on services by promoting autonomy and resilience, thereby improving well-being and self-management of health. This way of working has a long history in the voluntary and community sector but has only recently been widely funded by the National Health Service (NHS) in England and implemented in Primary Care Networks (PCNs). The COVID-19 global pandemic coincided with this new service. There is wide variation in how social prescribing is implemented and scant evidence comparing different delivery models. As embedded researchers within an Integrated Care System in the Southwest of England, we examined the impact of COVID on the implementation of social prescribing in different employing organisations during the period March 2020 to April 2021. Data were collected from observations and field notes recorded during virtual interactions with over 80 social prescribing practitioners and an online survey of 52 social prescribing practitioners and middle managers. We conceptualise social prescribing as a pathway comprising access, engagement and activities, facilitated by workforce and community assets and strategic partnerships. We found that these elements were all impacted by the pandemic, but to different degrees according to the way the service was contracted, whether referrals (access) and approach (engagement) were universal ('open') or targeted ('boundaried') and the extent to which practitioners' roles were protected or shifted towards immediate COVID-specific work. Social prescribers contracted in PCNs were more likely to operate an 'open' model, although boundaries were developing over time. We suggest the presence of an explicit, agreed delivery model (whether 'open' or 'boundaried') might create a more coherent approach less likely to result in practitioner role drift, whilst allowing flexibility to adjust to the pandemic and enhancing practitioner satisfaction and well-being. The potential consequences of different models are examined. Copyright © 2022 The Authors. Health and Social Care in the Community published by John Wiley & Sons Ltd.

Exploring the work and organisation of local Healthwatch in England: a mixed-methods ethnographic study
Item Type: Journal Article
Authors: Zoccatelli, Giulia;Desai, Amit;Robert, Glenn;Martin, Graham and Brearley, Sally
Publication Date: 2022
Journal: National Institute for Health and Care Research
Abstract: BACKGROUND: Local Healthwatch organisations are an important part of the landscape of health and care commissioning and provision in England. In addition, local Healthwatch organisations are a key means by which users of services are given voice to influence decisions about health and care commissioning and provision. OBJECTIVE: We aimed to explore and enhance the operation and impact of local Healthwatch in ensuring effective patient and public voice in the

commissioning and provision of NHS services. DESIGN: We used mixed methods, including a national survey (96/150 responses, 68%); actor network theory-inspired ethnographic data collection in five local Healthwatch organisations (made up of 75 days' fieldwork, 84 semistructured interviews, 114 virtual interviews, observations during the COVID-19 pandemic and documentary analysis) and serial interviews about experiences during the pandemic with 11 Healthwatch staff and four volunteers who were members of a Healthwatch Involvement Panel (which also guided data collection and analysis). Finally, we ran five joint interpretive forums to help make sense of our data. SETTING: Our five Healthwatch case study organisations are of varying size and organisational form and are located in different parts of England. RESULTS: We found significant variation in the organisation and work of Healthwatch organisations nationally, including hosting arrangements, scale of operations, complexity of relationships with health and care bodies, and sources of income beyond core funding. Key points of divergence that were consequential for Healthwatch activities included the degree of autonomy from host organisations and local understandings of accountability to various constituencies. These points of divergence gave rise to very different modes of operation and different priorities for enacting the nationally prescribed responsibilities of Healthwatch organisations locally. Large variations in funding levels created Healthwatch organisations that diverged not just in scale but in focus. As the COVID-19 pandemic unfolded, Healthwatch found new approaches to giving voice to the views of the public and formed effective relationships with other agencies. RECOMMENDATIONS: We identified generalisable principles of good practice regarding the collection and communication of evidence. Policy implications relate to (1) the overall funding regime for Healthwatch and potential inequalities in what is available to local populations and (2) the development of Healthwatch's role given the evolution of local health and care systems since 2012. FUTURE WORK: Future studies should explore (1) the consequences of the development of integrated care systems for local Healthwatch organisations, (2) Healthwatch in an international comparative perspective, (3) how the response to the COVID-19 pandemic has reconfigured the voluntary sector locally and (4) how Healthwatch responds formally and informally to a newly emerging focus on public health and health inequalities. LIMITATIONS: The survey sought only self-reported information on impact and we were unable to recruit a Healthwatch that hosted several contracts. CONCLUSIONS: The diversity of the Healthwatch network belies its otherwise unitary appearance. This diversity - especially in differential funding arrangements - has considerable implications for equity of access to influencing health and care planning and provision for residents across England. FUNDING: This project was funded by the National Institute for Health and Care Research (NIHR) Health and Social Care Delivery Research programme and will be published in full in Health and Social Care Delivery Research; Vol. 10, No. 32. See the NIHR Journals Library website for further project information.

Community empowerment and mental wellbeing: longitudinal findings from a survey of people actively involved in the big local place-based initiative in England.
Item Type: Journal Article
Authors: Akhter, N.;McGowan, V. J.;Halliday, E.;Popay, J.;Kasim, A. and Bambra, C.
Publication Date: 2022
Journal: Journal of Public Health
Abstract: BACKGROUND: Community empowerment initiatives are receiving increased interest as ways of improving health and reducing health inequalities. PURPOSE: Longitudinally examine associations between collective control, social-cohesion and mental wellbeing amongst participants in the Big Local community empowerment initiative across 150 disadvantaged areas of England. METHODS: As part of the independent Communities in Control study, we analysed nested cohort survey data on mental wellbeing (Short Warwick Edinburgh Mental Wellbeing Scale-SWEMWBS) and perceptions of collective control and social-cohesion. Data were obtained in 2016, 2018 and 2020 for 217 residents involved in the 150 Big Local areas in England. Adjusted linear mixed effect models were utilized to examine changes in SWEMWBS over the three waves. Subgroup analysis by gender and educational level was conducted. RESULTS: There was a significant 1.46 (0.14, 2.77) unit increase in mental wellbeing score at wave 2 (2018) but not in wave 3 (2020) (0.06 [-1.41, 1.53]). Across all waves, collective control was associated with a significantly higher mental wellbeing score (3.36 [1.51, 5.21]) as was social cohesion (1.09 [0.19, 2.00]). Higher educated participants (1.99 [0.14, 3.84]) and men (2.41 [0.55, 4.28]) experienced significant increases in mental wellbeing in 2018, but lower educated participants and women did not. CONCLUSION: Collective control and social cohesion are associated with better mental wellbeing amongst residents engaged with the Big Local initiative. These health benefits were greater amongst men and participants from higher educational backgrounds. This suggests that additional care must be taken in future interventions to ensure that benefits are distributed equally. Copyright © The Author(s) 2022. Published by Oxford University Press on behalf of Faculty of Public Health.

Making a difference: workforce skills and capacity for integrated care
Item Type: Journal Article
Authors: AKEHURST, Joy
Publication Date: 2021
Journal: Journal of Integrated Care , pp. 2021
Abstract: Purpose: The aim of this action research was to explore, from a workforce and a patient/carer perspective, the skills and the capacity required to deliver integrated care and to inform future workforce development and planning in a new integrated care system in England. Design/methodology/approach: Semi-structured interviews and focus groups with primary, community, acute care, social care and voluntary care, frontline and managerial staff and with patients and carers receiving these services were undertaken. Data were explored using framework analysis. Findings: Analysis revealed three overarching themes: achieving teamwork and integration, managing demands on capacity and capability and delivering holistic and user-centred care. An organisational development (OD) process was developed as part of the action research process to facilitate the large-scale workforce changes taking place. Research limitations/implications: This study did not consider workforce development and planning challenges for nursing and care staff in residential, nursing care homes or domiciliary services. This part of the workforce is integral to the care pathways for many patients, and in line with the current emerging national focus on this sector, these groups require further examination. Further,

data explore service users' and carers' perspectives on workforce skills. It proved challenging to recruit patient and carer respondents for the research due to the nature of their illnesses. Practical implications: Many of the required skills already existed within the workforce. The OD process facilitated collaborative learning to enhance skills; however, workforce planning across a whole system has challenges in relation to data gathering and management. Ensuring a focus on workforce development and planning is an important part of integrated care development. Social implications: This study has implications for social and voluntary sector organisations in respect of inter-agency working practices, as well as the identification of workforce development needs and potential for informing subsequent cross-sector workforce planning arrangements and communication. Originality/value: This paper helps to identify the issues and benefits of implementing person-centred, integrated teamworking and the implications for workforce planning and OD approaches.

Implementing asset-based integrated care: a tale of two localities.
Item Type: Journal Article
Authors: Duggal, Sandhya;Miller, Robin and Tanner, Denise
Publication Date: 2021
Journal: International Journal of Integrated Care 21(4), pp. 19
Abstract: BACKGROUND: To date, few studies have examined the implementation of asset-based integrated care in the UK. This paper aims to address this gap in knowledge through examining the implementation of one model of asset-based integrated care, Local Area Coordination (LAC), within two localities in England. METHODS: This paper draws upon data collected from two local authorities (site A and site B), which had both implemented LAC. Using a case study approach, qualitative data was collected from interviews with relevant stakeholders both internal and external to the local authorities. Data was analysed thematically. RESULTS: The findings demonstrate the marked differences between the two sites' approaches to LAC, especially in relation to: the implementation process; impact; and their collaboration with other agencies and communities. DISCUSSION: The evidence presented in this paper demonstrates that the implementation of LAC, as with most complex service innovations, is dependent on the interplay of organisational and people-based components. In particular, successful implementation depends on maintaining a common vision of what an intervention will achieve and how it will work in practice, continual engagement with the political and organisational leaders of influence, positively addressing the anxieties of existing services and professions, and working with community groups.

What does Success Look Like for Leaders of Integrated Health and Social Care Systems? a Realist Review.
Item Type: Journal Article
Authors: Sims, Sarah;Fletcher, Simon;Brearley, Sally;Ross, Fiona;Manthorpe, Jill and Harris, Ruth
Publication Date: 2021
Journal: International Journal of Integrated Care [Electronic Resource] 21(4), pp. 26
Abstract: INTRODUCTION: Health and social care services in England are moving towards greater integration, yet little is known about how leadership of integrated care teams and systems can be supported and improved. This realist review explores what works about the leadership of integrated care teams and systems, for whom, in what circumstances and why. METHODS: A realist synthesis approach was undertaken in 2020 to explore English language literature on the leadership of integrated care teams and systems, complemented by ongoing stakeholder consultation. RESULTS: Evidence was identified for seven potentially important components of leadership in integrated care teams and systems: 'inspiring intent to work

together'; 'creating the conditions'; 'balancing multiple perspectives'; 'working with power'; 'taking a wider view'; 'a commitment to learning and development' and 'clarifying complexity'. DISCUSSION: Research into the leadership of integrated care teams and systems is limited, with ideas often reverting to existing framings of leadership, where teams and organisations are less complex. Research also often focuses on the importance of who the leader is rather than what they do. CONCLUSION: This review has generated new perspectives on the leadership of integrated care teams and systems that can be built upon, developed, and tested further. Copyright: © 2021 The Author(s).

Sharing leadership: current attitudes, barriers and needs of clinical and non-clinical managers in UK's integrated care system.
Item Type: Journal Article
Authors: Aufegger, Lisa;Alabi, Monica;Darzi, Ara and Bicknell, Colin
Publication Date: 2020
Journal: BMJ Leader 4(3), pp. 128-134
Abstract: BACKGROUND: As systems become more complex, shared leadership (SL) has been suggested to have a dominant role in improving cross-functional working tailored to organisational needs. Little, however, is known about the benefits of SL in healthcare management, especially for UK's recently formed integrated care system (ICS). The aim of this study was to understand current attitudes, barriers and needs of clinical and non-clinical managers sharing leadership responsibilities in the ICS. METHOD: Twenty clinical and non-clinical leaders in 15 organisations were interviewed to understand current cross-functional leadership collaborations, and the potential SL may have on the recently established ICS in the National Health Service (NHS). The data were transcribed and analysed thematically. RESULTS: Findings showed perceptions and experiences of clinical and non-clinical healthcare management in relation to: (1) motivation to execute a leadership position, including the need to step up and a sense of duty; (2) attitudes towards interdisciplinary working, which is reflected in conflicts due to different values and expertise; (3) SL skills and behaviours, including the need for mutual understanding and cooperative attitudes by means of effective communication and collaboration; and (4) barriers to achieve SL in the ICS, such as bureaucracy, and a lack of time and support. CONCLUSIONS: SL may help improve current leadership cultures within the NHS; however, for SL to have a tangible impact, it needs to be delivered as part of leadership development for doctors in postgraduate training, and development programmes for aspiring, emerging and established leaders, with clear lines of communication. [Abstract]

The working of a primary care network in Wirral: experiences thus far. Abstract only*
Item Type: Journal Article
Authors: Jones, Caroline
Publication Date: Jul 02 ,2020
Journal: British Journal of Community Nursing 25(7), pp. 353-355
Abstract: In order to meet the unique needs of local populations, health and care providers need to come together as a collective. A model of integration in line with the NHS Long Term Plan will support transformation, sustainability and meeting the increasing demands on the NHS. Due the complexity and variety of services in care communities, it is vital that organisations and the third sector acknowledge and understand one another with greater depth. Primary care networks (PCNs) support this by dissolving organisational boundaries, with services wrapping around each other and moving forward as one system. This article describes how one

PCN in Wirral committed to appreciating each service's roles. By engaging regularly in different ways, members of the PCN were able build on professional relationships. The refocusing and reconnecting regularly as a collective team enabled a more streamlined approach to proactive, place-based patient care while providing professionals with improved working relationships, skill-sharing and increased job satisfaction.

Scaling up: The politics of health and place.
Item Type: Journal Article
Authors: Bambra, Clare;Smith, Katherine E. and Pearce, Jamie
Publication Date: 2019
Journal: Social Science & Medicine 232, pp. 36-42
Abstract: Research into the role of place in shaping inequalities in health has focused largely on examining individual and/or localised drivers, often using a context-composition framing. Whilst this body of work has advanced considerably our understanding of the effects of local environments on health, and re-established an awareness of the importance of place for health, it has done so at the expense of marginalising and minimising the influences of macro political and economic structures on both place and health. In this paper, we argue that: (i) we need to scale up our analysis, moving beyond merely analysing local horizontal drivers to take wider, vertical structural factors into account; and (ii) if we are serious about reducing place-based health inequalities, such analysis needs be overtly linked to appropriate policy levers. Drawing on three case studies (the US mortality disadvantage, Scotland's excess mortality, and regional health divides in England and Germany) we outline the theoretical and empirical value of taking a more political economy approach to understanding geographical inequalities in health. We conclude by outlining the implications for future research and for efforts to influence policy from 'scaling up' geographical research into health inequalities.

Integrated care systems and nurse leadership. Abstract only*
Item Type: Journal Article
Authors: Duncan, Monica
Publication Date: Nov 02 ,2019
Journal: British Journal of Community Nursing 24(11), pp. 538-542
Abstract: There will be significant changes to the way in which primary and community health services are provided in the wake of the NHS Long Term Plan published in January 2019. Community nurses are already preparing themselves for these changes by exploring models of care that are patient-centred and link to neighbourhood, place and system levels. This article discusses two examples of such models of care, the Buurtzorg and Embrace model, both from the Netherlands. Styles of leadership and associated development, both within nursing and on a multi-professional basis will be crucial to ensure success. This article outlines Alban-Metcalfe's engaging transformational leadership model as a potential platform to move to flatter, more diverse teams and collective leadership.

Integrated care systems: what can current reforms learn from past research on regional co-ordination of health and care in England?: a literature review.
Item Type: Journal Article
Authors: Lorne, Colin;Allen, Pauline;Checkland, Kath;Osipovič, Dorota;Sanderson, Marie;Hammond, Jonathan;Peckham, Stephen and Policy Research Unit in Commissioning and the Healthcare System
Publication Date: 2019
Abstract: The integration of health and social care at a 'system' level is currently a central NHS policy priority in England. The NHS Long Term Plan sets out how organisations are to continue to work together collaboratively as Integrated Care

Systems (ICSs) and Sustainability and Transformation Partnerships (STPs) with the aim of improving co-ordination of local health and care services to encourage the better use of resources and through managing population health. In addition, seven new regional teams bring together NHS England and NHS Improvement at a regional level, intended to harmonise their operations for system-wide working. This report presents the findings of a literature review examining research into previous intermediate tiers in the NHS. Despite undergoing continuous reinvention, an intermediate or regional tier has existed for most of the history of the English NHS, with statutory authorities responsible variously for long-term strategic planning, allocating resources, acting as market umpires, and overseeing delivery of local health services. The latest reforms mark a return of an intermediate tier, however, unlike previous health authorities, STPs and ICSs are not statutory bodies but instead exist as non-statutory partnerships. Without change to legislation, encouraging system-wide collaboration marks a major shift in policy direction away from the primacy of quasi-market competition.

Integrated care systems in the English NHS: a critical view
Item Type: Journal Article
Authors: Ruane, Sally
Publication Date: 2019
Journal: Archives of Disease in Childhood 104(11), pp. 1024-1026
The intriguing evolution of health policy in recent years has implications for all parts of the health system. With the UK falling behind most high-income countries on many measures of child health1 and growing evidence of a worrying health gap between UK children in deprived and affluent areas,2 paediatricians and others working in child health will want to remain abreast of the broader policy backdrop even where child health has not been privileged in policymaking.

While the 2012 Health and Social Care Act reinforced the fragmentation of the service through multiple providers in competition with one another, subsequent policy promises local collaboration and joint working. This article traces this evolution and asks what it means.

Understanding new models of integrated care in developed countries: a systematic review
Item Type: Journal Article
Authors: Baxter, Susan;Johnson, Maxine;Chambers, Duncan;Sutton, Anthea;Goyder, Elizabeth and Booth, Andrew
Publication Date: 2018
Journal: NIHR Journals Library
Abstract: BACKGROUND: The NHS has been challenged to adopt new integrated models of service delivery that are tailored to local populations. Evidence from the international literature is needed to support the development and implementation of these new models of care. OBJECTIVES: The study aimed to carry out a systematic review of international evidence to enhance understanding of the mechanisms whereby new models of service delivery have an impact on health-care outcomes. DESIGN: The study combined rigorous and systematic methods for identification of literature, together with innovative methods for synthesis and presentation of findings. SETTING: Any setting. PARTICIPANTS: Patients receiving a health-care service and/or staff delivering services. INTERVENTIONS: Changes to service delivery that increase integration and co-ordination of health and health-related services. MAIN OUTCOME MEASURES: Outcomes related to the delivery of services, including the views and perceptions of patients/service users and staff. STUDY DESIGN: Empirical work of a quantitative or qualitative design. DATA SOURCES: We searched electronic databases (between October 2016 and March 2017) for research published from 2006 onwards in databases including MEDLINE, EMBASE, PsycINFO,

Cumulative Index to Nursing and Allied Health Literature, Science Citation Index, Social Science Citation Index and The Cochrane Library. We also searched relevant websites, screened reference lists and citation searched on a previous review. REVIEW METHODS: The identified evidence was synthesised in three ways. First, data from included studies were used to develop an evidence-based logic model, and a narrative summary reports the elements of the pathway. Second, we examined the strength of evidence underpinning reported outcomes and impacts using a comparative four-item rating system. Third, we developed an applicability framework to further scrutinise and characterise the evidence. RESULTS: We included 267 studies in the review. The findings detail the complex pathway from new models to impacts, with evidence regarding elements of new models of integrated care, targets for change, process change, influencing factors, service-level outcomes and system-wide impacts. A number of positive outcomes were reported in the literature, with stronger evidence of perceived increased patient satisfaction and improved quality of care and access to care. There was stronger UK-only evidence of reduced outpatient appointments and waiting times. Evidence was inconsistent regarding other outcomes and system-wide impacts such as levels of activity and costs. There was an indication that new models have particular potential with patients who have complex needs. LIMITATIONS: Defining new models of integrated care is challenging, and there is the potential that our study excluded potentially relevant literature. The review was extensive, with diverse study populations and interventions that precluded the statistical summary of effectiveness. CONCLUSIONS: There is stronger evidence that new models of integrated care may enhance patient satisfaction and perceived quality and increase access; however, the evidence regarding other outcomes is unclear. The study recommends factors to be considered during the implementation of new models. FUTURE WORK: Links between elements of new models and outcomes require further study, together with research in a wider variety of populations. STUDY REGISTRATION: This study is registered as PROSPERO CRD37725. FUNDING: The National Institute for Health Research Health Services and Delivery Research programme. Copyright © Queen's Printer and Controller of HMSO 2018. This work was produced by Baxter et al. under the terms of a commissioning contract issued by the Secretary of State for Health and Social Care. This issue may be freely reproduced for the purposes of private research and study and extracts (or indeed, the full report) may be included in professional journals provided that suitable acknowledgement is made and the reproduction is not associated with any form of advertising. Applications for commercial reproduction should be addressed to: NIHR Journals Library, National Institute for Health Research, Evaluation, Trials and Studies Coordinating Centre, Alpha House, University of Southampton Science Park, Southampton SO16 7NS, UK.

[A qualitative exploration of stakeholder perceptions of the implementation of place-based working and its potential to reduce health inequality]

Author(s): Steer and Machin
Source: Journal of Public Health 40(4) pp. 813-819
Publication date: December 2018
Background: Local authorities (LAs) have statutory responsibility to reduce health inequalities and improve public health. Place-based approaches may positively influence service provision yet little is known about their implementation and potential for reducing inequality through health and wellbeing improvements. An English LA implemented a place-based working (PBW) pilot in a small geography during austerity measures in the north of England. This involved three strands (early intervention, estate services and community intelligence) which were introduced separately and covered

overlapping geographies. Predominantly focusing on early intervention, this qualitative study investigates stakeholders' perceptions of the pilot and its potential to improve health and wellbeing by reducing inequality. Methods: In total, 15 face-to-face qualitative interviews with stakeholders were completed. Thematic analysis produced context, mechanism and outcome configurations in a process adapted from realist evaluation methodology. Results: Stakeholders described PBW as holistic, upstream and cutting across departmental boundaries to engage staff and the community. Collaborative working was considered important and was aided by PBW in our study. Conclusions: PBW has the potential to reduce health inequalities by improving health and wellbeing. LAs deliver services that affect health and wellbeing and PBW may help develop a more coordinated response to improve outcomes and potentially save money

The international knowledge base for new care models relevant to primary care-led integrated models: a realist synthesis
Item Type: Journal Article
Authors: Turner, Alison;Mulla, Abeda;Booth, Andrew;Aldridge, Shiona;Stevens, Sharon;Begum, Mahmoda and Malik, Anam
Publication Date: 2018
Journal: NIHR Journals Library
Abstract: BACKGROUND: The Multispecialty Community Provider (MCP) model was introduced to the NHS as a primary care-led, community-based integrated care model to provide better quality, experience and value for local populations. OBJECTIVES: The three main objectives were to (1) articulate the underlying programme theories for the MCP model of care; (2) identify sources of theoretical, empirical and practice evidence to test the programme theories; and (3) explain how mechanisms used in different contexts contribute to outcomes and process variables. DESIGN: There were three main phases: (1) identification of programme theories from logic models of MCP vanguards, prioritising key theories for investigation; (2) appraisal, extraction and analysis of evidence against a best-fit framework; and (3) realist reviews of prioritised theory components and maps of remaining theory components. MAIN OUTCOME MEASURES: The quadruple aim outcomes addressed population health, cost-effectiveness, patient experience and staff experience. DATA SOURCES: Searches of electronic databases with forward- and backward-citation tracking, identifying research-based evidence and practice-derived evidence. REVIEW METHODS: A realist synthesis was used to identify, test and refine the following programme theory components: (1) community-based, co-ordinated care is more accessible; (2) place-based contracting and payment systems incentivise shared accountability; and (3) fostering relational behaviours builds resilience within communities. RESULTS: Delivery of a MCP model requires professional and service user engagement, which is dependent on building trust and empowerment. These are generated if values and incentives for new ways of working are aligned and there are opportunities for training and development. Together, these can facilitate accountability at the individual, community and system levels. The evidence base relating to these theory components was, for the most part, limited by initiatives that are relatively new or not formally evaluated. Support for the programme theory components varies, with moderate support for enhanced primary care and community involvement in care, and relatively weak support for new contracting models. STRENGTHS AND LIMITATIONS: The project benefited from a close relationship with national and local MCP leads, reflecting the value of the proximity of the research team to decision-makers. Our use of logic models to identify theories of change could present a relatively static position for what is a dynamic programme of change. CONCLUSIONS: Multispecialty Community Providers can be described as complex adaptive systems (CASs) and, as such, connectivity, feedback loops,

system learning and adaptation of CASs play a critical role in their design. Implementation can be further reinforced by paying attention to contextual factors that influence behaviour change, in order to support more integrated working. FUTURE WORK: A set of evidence-derived 'key ingredients' has been compiled to inform the design and delivery of future iterations of population health-based models of care. Suggested priorities for future research include the impact of enhanced primary care on the workforce, the effects of longer-term contracts on sustainability and capacity, the conditions needed for successful continuous improvement and learning, the role of carers in patient empowerment and how community participation might contribute to community resilience. STUDY REGISTRATION: This study is registered as PROSPERO CRD42016039552. FUNDING: The National Institute for Health Research Health Services and Delivery Research programme.

Anchor institutions

Reports, guides, and explainers

Unlocking the NHS's social and economic potential: a maturity framework
Source: NHS Confederation
Publication date: December 2022
The new Health and Care Act (2022) this year for integrated care system (ICS) working will not only give a basis to improve health outcomes, tackle inequalities and enhance value for money, but will also for the first time give the NHS the permitted opportunity to support broader social and economic development for distinct communities. We must always acknowledge that the NHS makes a significant contribution to GDP, employment and economic activity, as well as providing a comprehensive medical and care service available to all. The new legislation supports an integrated and therefore more holistic approach to supporting people where they live, learn and work. This then in turn supports health service provision, especially in areas such as cancer, diabetes, heart disease, mental health and stroke, alongside a longer term move to preventative health.

The impact of community anchor organisations on the wider determinants of health
Source: Locality
Publication date: March 2022
As part of the VCSE Health and Wellbeing Alliance, Locality (in consortium with Power to Change) have been working with the government's Office for Health Improvement and Disparities (OHID) to research the impact of community anchor organisations on the wider determinants of health. This includes

understanding how they impact those experiencing health inequalities in their communities.

Anchor institutions: innovating through partnership in challenging times
Source: NHS Confederation
Publication date: 7th February 2022
Anchor institutions are large organisations such as NHS trusts, which are unlikely, by their nature, to relocate, have a significant stake in their local area as a result and have sizeable assets which can be used to support local community health and wellbeing, including tackling health inequalities.

Anchor institutions and how they can affect people's health
Author(s): David Maguire
Source: The King's Fund
Publication date: 8th September 2021
It is well known that socio-economic factors play a huge role in determining people's long-term health, and contribute significantly to the health inequalities that exist across England. Anchor institutions are large organisations that are unlikely to relocate and have a significant stake in their local area. They have sizeable assets that can be used to support their local community's health and wellbeing and tackle health inequalities, for example, through procurement, training, employment, professional development, and buildings and land use.

The NHS as an anchor institution
Source: Health Foundation
First developed in the US, the term anchor institutions refers to large, typically non-profit, public sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchors get their name because they are unlikely to relocate, given their connection to the local population, and have a significant influence on the health and wellbeing of communities.
The Health Foundation worked in partnership with the Centre for Local Economic Strategies (CLES) and The Democracy Collaborative to understand how NHS organisations act as anchor institutions in their local communities and can positively influence the social, economic and environmental conditions in an area to support healthy and prosperous people and communities.

Anchors and social value
Source: NHS England
The Health Foundation describes anchor institutions as large organisations whose long-term sustainability is tied to the wellbeing of the populations they serve.
These organisations are 'rooted in place' and have significant assets and resources which can be used to influence the health and wellbeing of their local community. By strategically and intentionally managing their resources and operations, anchor institutions can help address local social, economic and environmental priorities in order to reduce health inequalities.
Examples of anchor institutions include:

- NHS Trusts
- local authorities
- universities

See also Health Anchors Learning Network

ICSs, ICPs, and anchor organisations
Source: Good Governance Institute
Publication date: 4th December 2020
The value of anchor institutions has been explored well by the Health Foundation in recent months. Its report, Building healthier communities: the role of the NHS as an anchor

institution, sets out the positive social and economic impact of large, public sector organisations.
The term 'anchor' refers to the permanence of these organisations and their significant stake in a geographical area, linked to the wellbeing of a local population.
Perhaps it was an early sign of the complexity of this topic when one CEO at a GGI event dismissed anchor as an unhelpful metaphor as it was associated with not moving anywhere rather than moving with agility, and with creating a negative drag along the bottom, rather than positive forward momentum.

Health as the new wealth: The NHS's role in economic and social recovery
Source: NHS Reset and NHS Confederation
Publication date: September 2020
This report looks beyond the immediate health response to COVID-19 to understand where and how the NHS is actively supporting the nation's critical economic and social recovery.

Anchor institutions: best practice to address social needs and social determinants of health
Author(s): Koh et al.
Source: American Journal of Public Health 110(3) pp. 309-316
Publication date: March 2020
"Anchor Institutions"—universities, hospitals, and other large, place-based organizations—invest in their communities as a way of doing business. Anchor "meds" (anchor institutions dedicated to health) that address social needs and social determinants of health have generated considerable community-based activity over the past several decades.
Yet to date, virtually no research has analyzed their current status or effect on community health. To assess the current state and potential best practices of anchor meds, we conducted a search of the literature, a review of Web sites and related public documents of all declared anchor meds in the country, and interviews with 14 key informants.
We identified potential best practices in adopting, operationalizing, and implementing an anchor mission and using specific social determinants of health strategies, noting early outcomes and lessons learned. Future dedicated research can bring heightened attention to this emerging force for community health.

Prosperous communities, productive places: how a deeper relationship with anchor businesses can drive place prosperity and business productivity
Source: Localis
Publication date: April 2019
Productive businesses need prosperous communities to thrive and grow – prosperous communities need productive and profitable businesses. This report argues the relationship is symbiotic. However, the local economic landscape has changed and the relationship between major business and "place" must now be renewed if local industrial strategies are to deliver local economic success. Recommending that new, local productivity deals should be forged, the report argues that West Sussex and Gatwick Airport now have a unique opportunity to pioneer this approach.

Health institutions as anchors: establishing proof of concept in the NHS
Source: CLES (The national organisation for local economies)
Publication date: August 2019
This research was commissioned by the Health Foundation, following their report, Building healthier communities: the role of the NHS as an anchor institution, which explores the ways in which NHS organisations act as anchor institutions in their local communities. This report from the Centre for Local Economic Strategies and The Democracy Collaborative considers health

institutions as anchors within the context of a broader community wealth building approach.

Building healthier communities: the role of the NHS as an anchor institution
Author(s): Reed et al.
Source: Health Foundation
Publication date: August 2019
Widening health inequalities and growing pressures on health care services have prompted a fundamental conversation about the role of the NHS in prevention and its broader influence in local communities. The British economy is one where wages and living standards are stagnating and 22% of the population live in poverty.1 People from the most socially deprived areas of England die nearly a decade earlier and spend 18 fewer years in good health than people born in the least deprived areas.2 And while health care services on their own are insufficient to overcome these inequalities, the NHS could make a far greater contribution to this goal: it is the largest employer in the country, spends billions on goods and services each year and controls significant land and physical assets – all of which make it a powerful 'anchor institution'. Anchor institutions are large, public sector organisations that are called such because they are unlikely to relocate and have a significant stake in a geographical area – they are effectively 'anchored' in their surrounding community. They have sizeable assets that can be used to support local community wealth building and development, through procurement and spending power, workforce and training, and buildings and land.

Community business and anchor institutions
Source: CLES (The national organisation for local economies)
Publication date: February 2019
This research funded by Power to Change looks at how community businesses and anchor institutions can better work together to evolve and realise their full potential, and build local wealth. Primary research in three localities – Liverpool, Bristol and Ipswich – identified a number of key barriers and challenges to better working, and recommendations are made targeted at a number of groups: Anchor institutions, community businesses, national policymakers, local policymakers and the community.

(£) The NHS as an anchor – taking forward the long term plan
Author(s): Sarah Reed and Dominique Allwood
Source: Health Service Journal (HSJ)
Publication date: 16th January 2019
There are huge opportunities to build on the aims set in the long-term plan to help maximise the role of the NHS as an anchor in its local communities by leveraging on it as an employer, procurer, purchaser and also a mode of social change. Contact your library for help with access https://www.hlisd.org/

Transforming communities? Exploring the roles of community anchor organisations in public service reform, local democracy, community resilience and social change
Source: What Works Scotland
Publication date: May 2018
This report explores the developing roles of key community sector organisations known as community anchors. It draws from six exemplar anchor organisations in Scotland to explore their roles in engaging with, leading and challenging public service reform; how public services and the state can better support community anchors and community sector development; and the potential roles of anchors in building local democracy, community resilience for sustainable development, and wider social change.

The NHS as an anchor
Source: The Health Foundation
Publication date: 28th March 2018
How can health care organisations maximise their resources to improve population health?
The Five Year Forward View and evolution towards integrated care systems have placed greater expectations on the NHS to work across a geographical area and maximise its resources to improve the health of a local population. And while this focus on place-based systems of care has spurred developments in the way services are designed and delivered to help prevent ill health and promote wellbeing, limited attention has been given to how the NHS can influence the economic conditions that help create health in the first place.

Community building through anchor institutions
Source: CLES (The national organisation for local economies)
Publication date: February 2017
This 2017 report documents 6 years of local wealth building work with anchor institutions in Preston. The report provides inspiration and practical ideas for organisations and places seeking to use procurement to recirculate wealth locally.

Maximizing the local impact of anchor institutions: a case study of Leeds City Region
Source: Joseph Rowntree Foundation
Publication date: 16th January 2017
This report looks at anchor institutions in Leeds City Region, examining how the impact of these big spenders can be maximised for the region as a whole.
See also a Progressive Framework

Journal articles

Taking one step further: five equity principles for hospitals to increase their value as anchor institutions.
Item Type: Journal Article
Authors: Allen, Matilda;Marmot, Michael and Allwood, Dominique
Publication Date: Nov ,2022
Journal: Future Healthcare Journal 9(3), pp. 216-221
Abstract: Hospitals have the potential to create value beyond the direct clinical care that they provide through tackling the social determinants of health as an 'anchor institution': shifting the way in which they employ staff; procure goods and services; use their physical and environmental resources and assets; and partner with others. However, the societal value of this work is not automatically or accidentally created, it must be intentionally designed and delivered, particularly if it is to tackle inequities. This article proposes five equity principles for healthcare leaders to consider in their hospitals' anchor institution work. There have already been important shifts from the 'traditional way' of conceiving of a hospital's role in the community, but going 'one step further' could help to maximise the equity impact.

Communities with an anchor institution have higher coronavirus vaccination rates.
Item Type: Journal Article
Authors: Harris, Alexandra;Maechling, Claude R.;Holl, Jane L. and McHugh, Megan
Publication Date: July 2022
Journal: Journal of Rural Health 39(1), pp. 61-68
Abstract: PURPOSE: Anchor institutions ("anchors") are large employers, rooted in a community by reason of mission, capital, or relationships. Many anchors have encouraged coronavirus

vaccination for employees and their families. Our objective was to determine whether the presence of an anchor was associated with a higher county-level vaccination rate. METHODS: A cross-sectional study focused on 745 small- and mid-sized US counties. We used data from the Centers for Disease Control and Prevention, Reference USA's US Business Database, Economic Innovation Group's Distressed Communities Index database, 2021 County Health Ratings and Rankings, 2020 US Presidential Election popular vote data, and National Center for Health Statistics urban-rural classification data. We constructed 3 explanatory variables of interest: a binary variable indicating whether the county had an anchor; a continuous variable representing the number of anchors within a county; and the percent of all workers in the county who were employed by an anchor. Multivariable linear regression models were adjusted for race/ethnicity, political party allegiance, rurality, economic distress, and prevalence of smoking and adult obesity. FINDINGS: Counties with an anchor had vaccination rates 2.31 (P Copyright © 2022 The Authors. The Journal of Rural Health published by Wiley Periodicals LLC on behalf of National Rural Health Association.

Conference abstract: Improving health inequalities and wellbeing through the development of NHS Anchor Institutions – the Advancing Quality Alliance (aqua) using a 'living laboratory' approach to understand and facilitate learning into how NHS organisations engage, learn and build collaborative capacity with place-based partners and local communities to create social value
Author(s): Rachel Volland
Source: International Journal of Integrated Care
Publication date: April 2022
The NHS Long Term Plan (2019) recognises the potential of NHS organisations, who are often the largest employer and procurer of services within a place, to think beyond the provision of care services. By connecting and collaborating with other public and voluntary sector organisations and harnessing the energy and passion of local communities NHS organisations can purposely use their social and economic power, by the way they recruit and employ local people, purchase goods and services and partner to sustainably develop the local environment and economy. aqua is an NHS health and care quality improvement membership organisation. Since 2012 aqua has designed and delivered a portfolio of programmes supporting health and care systems across the North West of England to develop integrated care services and improve population health and well-being.

The role of anchor institutions in creating value for SMEs: insights from North East of England owner-managers
Author(s): McCauley Smith et al.
Source: Studies in Higher Education 47(6)
Publication date: 2022
The roles universities are seen to play have changed significantly over the last 25 years. The concept of higher education has, and, continues to morph from a distanced, unengaged ivory tower to a highly engaged community-based concept. Yet there is little in the literature about how universities viewed as 'anchor institutions' support organisations. Further, there is an omission of specific detail about the impact of universities on SMEs; they are mentioned but only in broader terms. This empirical study is based on the results of a leadership and business development intervention for 50 UK SMEs. The intervention was facilitated and delivered by a North East University we recognise to be an 'anchor institution'. The study is longitudinal and embeds innovative composite measurement within a value creation framework with a specific focus on identifying how a North East anchored institution creates impact and value for SME owner-managers. Findings include leadership salience to SME owner-managers, increases

in SME turnover and significant gross value added. This study contributes to understanding about what the role of a university, as an anchor institution, is in terms of role, SME impact and value creation, with potential for international application.

Public value governance meets social commons: community anchor organisations as catalysts for public service reform and social change?
Author(s): Henderson et al.
Source: Local Government Studies 47(6)
Publication date: 2021
Scottish public service reform is one example of an emerging international vision for state-convened public value governance. Scottish Government focus on community empowerment has legitimised discussions of community-led approaches and offers cautious policy support for community anchor organisations. In this context, community studies scholars and community sector continue to reflect critically on complex relations between state and community, with some exploring a social commons as a distinctive aspiration for democratic governance. In this paper, our participatory research with six community anchor exemplars and wider stakeholders provides empirical material to support discussion, interpretation and analysis at 'the frontier' of these visions of governance. We consider the potential for anchors to offer collaborative leadership to facilitate cross-sector partnership and participation and agonistic leadership to provide countervailing, constructive challenge to the state. We conclude by advancing a research agenda to explore further community sector leadership at times of increasing social and ecological crisis.

Hospitals as anchor institutions: how the NHS can act beyonf healthcare to support communities
Author(s): Richard Vize
Source: BMJ 361
Publication date: May 2018
The NHS is exploring how it can use its local economic clout to benefit population health, finds Richard Vize
UK hospitals are exploring their potential as anchor institutions to use their financial, employment, and asset muscle to support local economies and tackle social determinants of health.

Case Studies

Multidisciplinary teams: Integrating care in places and neighbourhoods
Source: Social Care Institute for Excellence
Publication date: December 2022
Multidisciplinary teams (MDTs) are central to achieving the vision of Integrated Care Systems (ICSs) as they are a structured forum in which practitioners from across health and social care can come together around the needs of individuals and communities. MDTs need to have a clear role and purpose, be well led and organised, have sufficient diversity of professions and disciplines, and be supported by an enabling infrastructure. MDTs must be pro-active in how they engage individuals and families in their discussions and decision making. MDTs should also connect with other services and teams in their neighbourhoods and place.

Case studies of local collaboration
Source: NHS Providers
Publication date: July 2022
NHS Providers is undertaking a range of activities to support trusts to work effectively at place, including sharing examples, analysing and interpreting policy developments, and influencing national decision-makers.

Collaborating for better care
Source: NHS Providers
Publication date: June 2021
In this report we set out examples of a wide range of collaborations taking place across the country to show the complexity of arrangements.

Social determinants of health and the role of local government
Source: Local Government Association
Publication Date: 2020
See p. 18 for case studies
This report explores what local government can do to improve health especially by tackling social determinants. Health improvement has always been a fundamental responsibility of local government and this was emphasised further with the transfer of public health responsibilities in 2013. The report argues that there is little use in simply treating people for a health condition if the cause of that condition is not also addressed. Tackling social determinants includes improvements in housing, education and employment as well as ensuring a health promoting environment. Each of the social determinants of health can be improved to give an overall improvement in the health and wellbeing of communities. The roles that local government undertakes to improve health through tackling social determinants include: civic leadership; as employer and anchor institution; securing services; planning and licensing; as champion of prevention. Local government actions and services are centred around the improvement of wellbeing and the prevention of poor outcomes - this is true for children's services, adult social care and economic development among many others. Opportunities for health improvement by tackling the social determinants of health have been taken up across the country - the report includes detailed examples and case studies illustrating the opportunities for health improvement and what has already been achieved.

A citizen-led approach to health and care: lessons from the Wigan Deal
Author(s): Chris Naylor and Dan Wellings
Source: The King's Fund
Publication date: June 2019
This report provides an independent critique of the Wigan Deal, and its approach to delivering local services based on the idea of building a different relationship with local people. It looks at why it was developed, how it has been put into practice, and what others can learn from it. The report draws on in-depth research, including interviews with key stakeholders, focus groups with members of the public and evidence from data analysis. The transformation in Wigan included four main components: asset-based working, permission to innovate, investing in communities and place-based working. The report describes some of the outcomes that appear to demonstrate the impact of the Wigan Deal and explores the challenges involved in measuring this. The report shows it is possible to achieve savings while protecting or improving outcomes, but only if services are genuinely transformed and financial investment is available to help bring about new ways of working.

HEE Star

More resources and tools are available in the HEE Star

Statistics

You can find relevant statistics on the Health and Care Statistics Landscape under **"Health and Care"** and use the theme filters

HEE National Data Programme

HEE staff can look at the National Data Warehouse (NDL) SharePoint site to find out more about datasets and Tableau products.

*Help accessing articles or papers

Where a report/ journal article or resource is freely available the link has been provided. If an NHS OpenAthens account is required this has been indicated. It has also been highlighted if only the abstract is available. If you do not have an OpenAthens account you can self-register here.

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