Delivering together for residents

How collaborative working in places and communities can make a difference

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Foreword

The COVID-19 pandemic has presented local councils, health services and voluntary organisations with the biggest challenge since the creation of the NHS. It has also reminded us of the power of local and the enormous capacity for communities to come together during the most difficult times to help one another, provide support and give comfort.

Responding to a global pandemic at a local and regional level has required system leadership of the highest order as well as even closer collaboration between partners. Across the country the NHS and local councils have found innovative ways of working together at a neighbourhood, place, and system level, removing barriers that previously stood in the way of joined-up care and support. But the response to Covid-19 has been strongest where health and care partners have worked closely together as one system.

With Integrated Care Systems (ICSs) being established across England, the potential for us as partners to go even further and make real improvements to the lives of the people we serve is immense. ICSs are bringing local councils, health and care services and voluntary organisations together to work with communities to find new ways to ensure everyone has timely access to the treatment and support they need. ICS partners have a shared vision to reduce health inequalities in their communities, support broader social and economic development and enable residents to live healthy, independent lives, as they want to.

While some ICSs are relatively new and are still finding out what works best in each local area, or place, already there are outstanding examples of partnership working across England which are making a positive impact on the health and wellbeing of so many people. How we work nationally, regionally and locally to enable these partnerships to flourish will be so important for the future of the people and places we serve.

At Solace we are committed to strengthening the ways in which local authorities and the NHS work together. It is only through genuine partnership working that we will be able to collectively deliver better outcomes for our residents. So, as we focus on recovery from the pandemic, we must harness the desire to break down barriers at all levels, play to our respective strengths, and work together towards a common purpose. If we do that we will be better able to prevent and treat illness, and therefore drive up the quality of people's lives.

This is why I am delighted to share with you a few of the hugely encouraging local examples which demonstrate some of the scope for collaboration and remind ourselves of the benefits for the communities we serve and the wider health and care system. We are grateful to all those who took time to share with us their experiences of working together to find new ways to support people in their communities. They tell us what worked best but also describe some of the obstacles they encountered. A strong theme that runs through this collection of case studies is the importance of place. While relationships between local areas and ICSs will be different in different parts of the country, it is clear that empowering work to happen at a place level will be crucial if ICSs are to be successful at improving health outcomes.

This is not intended to be a definitive guide but we hope that you will find inspiration and embrace their learnings to inform your own work in your community. Above all, we hope it will inspire more local councils, health services and voluntary organisations to come together to codesign new models of care that improve lives.

Developing local solutions to national problems, including reimagining relationships between public and voluntary services, has been at the core of the pandemic response. Local teams have been empowered to do what they feel is necessary to reach people in need. These partnerships have helped to build resilience in communities and given residents confidence to confront the

challenge of COVID-19. Through the creation of ICSs we now have a golden opportunity to build on the foundations of those partnerships. By working together we can 'level up' the health and wellbeing of our communities, support social and economic development, and address the many health inequalities which have been further exposed and exacerbated by the pandemic.

Paul Najsarek, Solace Community Wellbeing spokesperson and Chief Executive, Ealing London Borough Council

Introduction

This publication has been produced by SOLACE in collaboration with NHS England and NHS Improvement and should be of interest to any organisation that commissions or provides health, social care, public health as well as other locally delivered services.

It is particularly timely with the government preparing to put integrated care systems (ICS) on a statutory footing with place-based partnerships as a key and essential component.

Both organisations have long advocated for joint planning and integrated service delivery between local government, the NHS and voluntary partners in order to improve outcomes for individuals and residents. The covid-19 response re-emphasised the need for strong local partnerships and implementation of the ambitions set out in the NHS Long Term Plan for ICSs and place-based partnerships.

This resource captures emerging practice from eight local partnerships of local government, health, housing and the voluntary sector that are making a positive impact on the health and wellbeing of their local communities. It focuses on the shared challenge, achievements, barriers and learnings which are helping to improve health and care and tackle wider determinants of health as well as inequalities.

We hope the following examples will show local health and care leaders how together they can improve health and care outcomes through integration and prevention and, in turn, make best use of resources and achieve sustainable service provision.

Background

The impact of the Covid-19 pandemic and the response seen in local communities has demonstrated the importance of partnership in times of crisis but also the need for health and care partnerships to support the long-term health and wellbeing of our population.

In recent years, local government, the NHS and voluntary organisations have increasingly come together to find innovative ways to address shared challenges associated with long-term health conditions. However, during the pandemic the pace of integration between these partners has accelerated as well as the appetite for joint working going forward.

As of April 2021, health and care partnerships across the totality of England have been established in the form of ICSs. The government intends to establish these as legal bodies by April 2022, providing a framework to the NHS, local authorities and the voluntary sector to work in partnership. The new ICS partnerships present an exciting opportunity to build on existing relationships to strengthen and develop work to support the health and care priorities of the local population.

Evidence consistently shows that the wider determinants of health – our homes and environment, access to public services, employment and educational opportunities - have the greatest impact on our overall health and wellbeing. By working together, in ICSs, local authorities and other partners can drive improvements in population health and tackle health inequalities by addressing social and economic determinants of health.

Already, there are many examples which show how collaboration and preventative approaches are having a positive impact on health and wellbeing outcomes as well as benefiting the wider health and care system. This publication highlights just a few examples of integrated health and care in practice.

Case Studies

Environmental quality

Tower Hamlets, London: Take A Breather Asthma and Wheeze Programme

Tower Hamlets Together is a group of health and social care organisations working closely together to improve the health and wellbeing of people living in the London Borough of Tower Hamlets. The partners are Tower Hamlets CCG, Tower Hamlets Council, Tower Hamlets Council for Voluntary Services, East London NHS Foundation Trust, Barts Health NHS Trust and Tower Hamlets GP Care Group.

The area has a population of around 280,000 people, attracting residents from all over the UK and wider international communities. It faces complex health challenges, with significant levels of poverty and high premature death rates. The population is mobile, relatively young and is expected to increase by around 20% over the next six years.

The challenge

Nationally, asthma is the most common long-term condition among children and young people. In Tower Hamlets, respiratory conditions are the leading cause of hospital admissions for children locally. In 2017 a local young person, Nasar Ahmed, sadly died in school at the age of 14 from a severe asthma attack triggered by anaphylaxis. Although the prevalence of respiratory conditions was already well-known, his death prompted the local community to focus on how partnerships could bring the community together to improve young people's lung health.

The approach

This resulted in a new programme called Take a Breather – Stopping the Monster Days. It began with children and young people with lung conditions, who were co-designers. Many of them said "*We just want to be able to breathe",* and that became the name of the programme: "Take a Breather". It was a five-year-old who said: "I want to stop the monster days."

More than 300 people were actively involved in the programme, including 170 system leaders, researchers and professionals delivering services and 69 children and young people.

The programme deployed a wide range of interventions. Health promotion included group consultations in schools, peer sessions for newly-diagnosed children after school and an app for young people. Asthma champions were identified across the borough. The programme also addressed environmental issues, such as smoking, with an emphasis on smoking cessation or reduction in family homes, and air quality, providing real-time information about levels of pollution in the borough.

The outcome

Take a Breather strengthened partnerships across health services, with clinicians working together in children's asthma services, high-risk clinics and pharmacies, supported by an integrated Asthma Action Plan.

The programme has already delivered strong population health outcomes. There has been a 25% increase in the number of children with a formal diagnosis of asthma and an increase in the proportion of patients with asthma care plans from 40% to 75%. More than 500 children at risk of asthma attacks were identified.

The original aim was to reduce unplanned admissions for children up to the age of 16 by 15% in 12 months. In fact they have fallen by 22%, and 92% of high-risk children have improved their asthma control.

Health professionals who have been involved say they have increased confidence and understanding of children with asthma and their families.

There has also been impact at a wider scale. The North East London Children and Young People Asthma Network has been established, promoting the use of a standardised asthma plan. There has been progress in system-wide IT integration, with the automation of discharge letters sent to school nurses from hospitals.

One of the underlying drivers of the programme's success was the application of a quality improvement (QI) methodology, already socialised in the NHS, in a partnership context. This enabled rapid testing of pilots and means many small-scale changes could take place at the same time. This pace is achieved through short, high-frequency meetings and allows space for partners to think broadly and collaborate across service boundaries.

The future

This work is continuing, with evaluation of outcomes and impact already helping to secure more asthma nurses in Tower Hamlets and other boroughs. Agreement of the same asthma plan template has allowed closer links between schools and hospitals. Through shared resources, the specialist nurse workforce has increased from one to eight in north-east London. Full development of the Young People Asthma App is ongoing with a view to embed this more widely. The programme is also building on existing partnerships with colleagues in housing to strengthen joint strategic needs assessment of health and housing.

This work has shown that poor asthma outcomes are not an inevitable feature of a population experiencing high levels of child poverty, overcrowding and poor air quality. These issues can be effectively addressed through strategic leadership, partnership working and QI methods to deliver rapid system change that improves children's health and wellbeing.

Homelessness

Doncaster: Complex Lives Alliance

The Doncaster Complex Lives Alliance supports rough sleepers with complex health needs. It is a delivery model which integrates the work of Doncaster Metropolitan Borough Council, Doncaster and Bassetlaw NHS Trust, Rotherham, Doncaster and South Humber NHS Trust (which includes Aspire, the drug and alcohol service), Primary Care Doncaster, NHS Doncaster Clinical Commissioning Group (CCG) - St Leger Homes, South Yorkshire Police, Criminal Justice, Department for Work and Pensions and community, voluntary and faith organisations. It aims to improve outcomes for people affected by multiple disadvantages, including rough sleeping, drug and alcohol addiction, offending behaviour, mental ill-health, and poor physical health.

Why rough sleepers?

Doncaster, like many towns and cities in the UK, has seen rising challenges related to rough sleeping. This has been mostly centred on the Doncaster town centre area. It has given rise to growing public, business and public service concerns about rough sleeping, poor physical and mental health, the use of synthetic cannabinoids, begging and anti-social behaviour.

During winter 2017/18, Doncaster was dealing with more than 30 rough sleepers in very challenging conditions, such as the so-called 'Beast from the East' cold spell. A very small number (five) could not be persuaded to take up offers of accommodation and support and chose to stay out all winter.

During the exceptionally warm weather in summer 2018, rough sleeper numbers reached 67. This placed unplanned and complex demands on a range of services, including the NHS, and there were concerns around the connection between A&E, hospital discharge and primary care services.

An assessment of the impact on public services, based on a cohort of 57 people with complex needs, indicated a conservative estimated annual cost to the public purse of £1 million. When scaled to the estimated total cohort of 4,200 people experiencing multiple disadvantages in Doncaster this totalled almost £50m a year of mostly reactive costs.

The approach

In Autumn 2016, Doncaster Council and the Team Doncaster Strategic Partnership identified the issue as a priority for the development of a new, whole system operating model. This reflected the complexity of the challenge and the need for an integrated response across all public services, working with community, voluntary and faith sectors.

Between November 2016 and May 2017, a wide range of partners were engaged in a participatory design process to create a new delivery model. This was underpinned by ethnographic surveys of people with lived experience of being locked into a cycle of rough sleeping, addiction, offending behaviour, poor physical and mental health and vulnerability. Deep engagement with local stakeholders ensured a 'bottom up' design process. It also established a core commitment to ensuring a user centred, strengths-based approach to the design and development of the model, which is still a key feature.

Following a short pilot phase, the Alliance fully launched in February 2017.The Alliance model has strong and accountable governance arrangements, with a joint commissioning approach across Doncaster Council's Adult Services, Public Health and the CCG.

The core team of key workers is financed by a Flexible Homelessness Support Grant of just over £300,000 a year via the Ministry of Housing, Communities and Local Government. This is supplemented by significant direct staff contributions and managerial and development support across partners. For example, the Rotherham, Doncaster and South Humber Community NHS Trust directly funds a specialist NHS nurse and the Community Rehabilitation Company provides a prison InReach worker from Nacro, the social justice charity.

The outcome

Since its launch, the Alliance has supported more than 300 people and achieved transformational success with some of the most entrenched rough sleepers in Doncaster with highly complex health and support needs. As of June 2021, the team is supporting 115 clients with complex needs, all of whom were rough sleepers. 102 of these are now settled and stabilised in accommodation settings, being supported by key workers and wrap-around support plans. They are making progress on initial stabilisation and with improvements in drug and alcohol misuse, physical health and offending behaviours.

Others are in a variety of settings including prison, detox programmes and a small number remain rough sleeping but are engaged with assertively to manage health and other concerns as far as possible.

The future

The Complex Lives Alliance is set to continue, as policy direction set out in the NHS Long Term Plan acknowledges the importance of a focus on homelessness and issues related to supporting people with complex lives. This provides a backdrop of policy support and investment to continue with integration and increasingly preventive approaches.

The foundations created in the Complex Lives Alliance provide a very helpful learning to inform how Integrated Health and Social Care forward in Doncaster is developed across South Yorkshire. There is important learning here nationally for the development of integrated health and social care services.

Housing

Gloucestershire Warm Homes - Park Homes

Warm and Well is a partnership between seven councils with the aim of tackling fuel poverty across Gloucestershire and South Gloucestershire. The partnership provides support, advice and access to grant funding to help households install energy efficiency measures. It is delivered by Severn Wye Energy Agency, a local sustainability charity.

NHS Gloucestershire CCG joined the Warm and Well partnership in 2016/17, recognising the impact of cold and inefficient homes on long-term health conditions, with a significant impact on the NHS. The Gloucestershire councils, including the county council, and the CCG formed a Strategic Housing Partnership (SHP) in order to use additional funds linked to the Better Care Fund and Disabled Facilities Grant (DFG).

Why park homes?

The consortium of partners identified park homes as a particular concern. Aside from the very newest properties, park homes are built without insulation, leaving only board and render between the occupier and the elements. Park home sites are privately owned, which means they are not typically eligible for Government funding schemes for insulation measures.

Health data analysis by the CCG found that hospital admission rates for park home residents are higher than the average for other residents across Gloucestershire, particularly for respiratory and circulatory conditions. There is a higher prevalence of congenital heart disease and chronic obstructive pulmonary disease among park home residents, who are also more likely to be smokers.

The combined issues of fuel poverty and the poor health this leads to presented park homes as an opportunity to use a collaborative approach between housing and health departments. By working together to use health data and a joint funding model, Warm and Well would be able to address the gap in funding for park home residents.

The approach

The District Council partners each agreed to allocate approximately £550,000 of their DFG aid budgets to cover the cost of external wall insulation to reduce heating costs and create a healthier home for park home residents. Allocated amounts varied according to need and availability in each district but in total this funding was sufficient to provide assistance to 90 park homes across Gloucestershire in a pilot project.

Benefits of this approach include:

- Alleviating fuel poverty, by making it less expensive to stay warm;
- Improving health outcomes by creating a better living environment and reducing the number of hospital visits and need for ongoing social care support;
- Reducing carbon emissions.

Park homes that were rented were a significant complication. Tenants were keen for the work to go ahead but did not own the properties. This was resolved by Severn Wye and the local council agreeing a set contribution in discussion with a large landlord to support those who were most in need. This meant the resident was not out of pocket, their health has been supported and the quality of local housing, which had been of concern, was improved. Insulation was applied to the outside of the property, rendered and painted, using materials with a 20-year guarantee.

Outcomes

The pilot project is expected to deliver savings to the NHS of around £400,000 and wider society of around £7m over the next five years. The savings over the lifetime of the insulation will be more than £2m. Total savings have been calculated by using a BRE score based on Energy Performance Certificates for the refurbished properties. This includes reducing pressure on the NHS through fewer A&E attendances by park home residents and cost savings on fuel bills and further maintenance on the properties. The average cost of installing insulation was £6,015 per property.

Feedback from park home residents has been very positive. 86% of residents have already noticed they are paying less (the homes have been insulated for varying timeframes between four weeks to one year). 88% said they felt warmer in their homes and 84% said that adaptations to the property had a positive impact on their day-to-day life.

One resident, Mrs R, said: “It’s been absolutely amazing. It’s so much warmer than before, I’ve only had to have my heating on at 18°C instead of 21°C. Everyone was really good. I could call up Warm and Well whenever. They listened; they didn’t talk at you which is really important.”

The future

Due to the success of the initial project the partnership has successfully bid for approximately £750,000 from the Green Homes Grant’s ‘Local Authority Delivery’ scheme to cover the cost of fitting external wall, loft or floor insulation as required to the park home properties of 100 low-income households across the county. Following this, a successful further bid was made for £1m from the same fund for improvement of over 100 more park homes. This will provide annual savings of around £1m to the NHS over five years.

Children and Young People

Coventry: Family Health and Lifestyles Service

Coventry City Council and South Warwickshire NHS Foundation Trust are working together to improve the health and wellbeing of children and families in the city. Coventry's 0-19 Family Health and Lifestyles Service includes: health visiting, family nurse partnership, infant feeding, family weight management, smoking cessation in pregnancy and school nursing.

The council undertook a new procurement process for the 0-19 service, described as "dialogue with negotiation". This allowed commissioners to articulate the vision and bidders to test ideas, stimulating innovative solutions and refining ideas before submission of the final proposal.

The challenge

Child obesity levels in Coventry are higher than the England average, with around 10% of Reception children and 23.6% of Year 6 children classed as obese. Excess weight levels are higher in areas of greater deprivation and among ethnic minorities. As a Marmot City, addressing health inequalities is a key priority for the city.

While there are many examples of positive engagement and joint working at the operational, front line level, the challenge is supporting the sustainability and resilience of organisations to carry the work forward, which would benefit from a more robust, systems-based approach to a population based, healthy weight ambition.

The approach

The service is delivered by public health leaders, who play a key role in early identification and intervention with a vision to:

- Equip all families with the knowledge and understanding of the importance of and ways to live healthy lifestyles. The integration of different services, sets the foundation for this, allowing key health promotion to be delivered by a variety of colleagues, wrapping care around the family in a seamless way and addressing health inequalities.
- Provide a service that is child and family focused. The collaboration of different specialities has allowed the service to increase the skill-set of all teams so that they feel empowered to deliver a variety of key health messages and to recognise need.
- Identify at an early stage those families experiencing problems before they escalate and promote protective factors.
- Provide specialist support to meet the needs of communities to address inequalities. This includes MAMTA, a voluntary organisation, which provides child and maternal health support for ethnic minority women in Coventry.
- Seek out ways to connect, communicate and collaborate with other partners across Coventry, to ensure health and care needs of families can be met.

The impact

Ethnic minority families get increased support to address their needs in a way that is culturally sensitive. MAMTA can ensure that families are getting access to the services they need and health messages are shared in a way that is meaningful to them. MAMTA gains an understanding of the needs of communities across Coventry and provide leadership on addressing the needs of ethnic minority communities across Family Health and Lifestyle Services.

More than 88% of MAMTA users who were followed up during the post-natal period (April 19 – March 2020) were still breastfeeding at six to eight weeks. Many case studies from the programme provide evidence of a positive impact.

The team delivered a total of 115 programmes throughout 2019/20, with 2,056 people signing up to make positive changes to their lifestyle. There was a spike in Q4 2020 as the service began to re-establish its presence in schools. In addition, the team delivered 136 health promotion activities in schools and community venues.

How will the approach be sustained?

Family Health and Lifestyles Service is now in its third year. Services are working in an integrated way, towards a common purpose. To develop the service further, on the team will focus on place-based needs. One example is where breast-feeding rates need to improve or there are high rates of smoking in pregnancy. This will help the design of pathways with other services and voluntary offers further.

The relationships that have developed over the initial years of this service, between the specialities, have allowed Family Health and Lifestyles to flourish. Colleagues are supported to learn from each other and make use of the expertise around them, adapting pathways as the needs of communities change. This will be key in addressing the consequences of the COVID-19 pandemic.

Adult Social Care

Bristol: Voluntary Sector Partnership for Discharge Support at Home

During the Covid-19 pandemic, the British Red Cross has been working with the NHS and local authorities to provide practical and emotional support for people being discharged from, or awaiting, hospital treatment through First Call – Support at Home. This is a flexible and responsive volunteer-led service which helps individuals to build independence and resilience when there is an increased need for support at home.

The challenge

The timely discharge of frail and vulnerable patients from hospital has long been recognised as a significant challenge for the NHS and social care. However, the pandemic has changed and created new challenges for the NHS, social care and voluntary services.

Hospitals across the country had significant capacity constraints while doing everything possible to keep patients and staff safe. Social care providers also suffered with logistical issues, including shortages of staff and suitable accommodation. This meant safe, effective discharge support was needed more than ever.

Nationally the British Red Cross had to adapt its health and wellbeing support, including the First Call team in Bristol, North Somerset and South Gloucestershire (BNSSG).

The solution

The First Call service in BNSSG worked in partnership with the NHS, local government and voluntary sector partners to help discharge patients from hospital in a safe and timely manner and to offer support at home which prevents re-admission and increases independence.

To achieve this the service offers four different tiers of support which can be adjusted depending on a person's changing needs and circumstances. The support delivered can be anything from a one-off welfare check call shortly after a person is discharged or following a medical appointment, to longer interventions from 6-12 weeks for people with more complex needs. The service helps to personalise and develop independence by involving families, neighbours and others in the community where appropriate and by making best use of community services and familiar support networks.

Due to the government's social distancing advice and guidance, many First Call volunteers had to adjust their support to include more telephone and video calls and less face-to-face. By drawing on their vast experience volunteers ensured that services could continue to meet the needs of people. For example, telephone welfare checks soon after discharge helped us to reassure people once they arrived home and identify and address any immediate issues, such as lack of food, medication or utilities, all of which could result in re-admission.

The BNSSG First Call team worked closely with other organisations such as GoodGym to share ideas on how a local partnership could collaborate to address emerging needs. They developed an enhanced referral pathway with GoodGym for people needing emergency food and medication drop-offs, which went from just two referrals in February 2020 to over 60 referrals by May 2020.

During the pandemic Red Cross staff and volunteers helped hospitals and social care teams to identify a patient's needs before discharge to ensure that appropriate arrangements could be made for support in the community. This has helped to speed up the discharge process while reassuring patients and their families that discharge could take place safely without exposing patients to avoidable risk in their homes.

The support includes:

- transport home from hospital and for essential health-care journeys
- help with everyday tasks (for example, picking up prescriptions and shopping)
- companionship
- rebuilding confidence
- help arranging for bills to be paid
- short-term use of a wheelchair and toilet aids.

The outcome

This partnership between the NHS, local government and the British Red Cross has had a positive impact on individuals and the wider health and care system, enabling more people to leave hospital without delay while supporting their recovery at home. This has reduced the risk of COVID-19 infection in hospital while releasing much needed capacity for other patients, and, through collection of patient feedback – a standard of the service - providing local systems with vital feedback to improve and enhance future support.

Despite the challenging environment posed by Covid19, the Bristol First Call team supported 1,791 people throughout 2020. A further 281 people were supported through additional resources the BNSSG team were funded to provide, alongside First Call, to reduce longer length of stay and to support winter pressures discharges.

From March 2020 to May 2021, the British Red Cross has supported thousands of people across the UK in partnership with hospitals and health partners. Successes include:

- 52,433 people helped home through hospital discharge support services plus a further 39,917 people supported through patient transport;
- 35,298 people received practical support at home;
- 3,311 medication deliveries, 13,340 food deliveries and 2,523 wheelchair loans
- 495,266 people supported at vaccination sites;

£3.37m disbursed through Hardship Fund and destitution payments.

The future

NHS England and NHS Improvement and the Local Government Association have developed a joint support offer for hospital discharge. It is intended to support local health and care systems to implement the Hospital Discharge Service for managing transfers of care.

Transportation services

Kirklees: covid-19 Vaccination Transport Services

Kirklees Council has been working with Kirklees CCG and the local primary care networks in a variety of ways to support the Covid-19 vaccination programme, involving a range of different teams from public health to the communications and IT teams. One of the most effective products of this partnership has been providing free transport for vulnerable people who were unable to reach vaccination centres.

The challenge

Vaccinations for Covid-19 got underway in England in December 2020, with ambitious targets to reach millions of people as quickly as possible. The programme began with the elderly and most vulnerable. This presented a logistical challenge for Kirklees to ensure that everyone was able to attend a vaccination centre.

The borough of Kirklees in West Yorkshire is home to 440,000 people. Huddersfield is the main town and administrative centre. There is a large rural area with a markedly older population. By late January 2021 there were five GP-led vaccination centres and three pharmacy-led clinics. A mass testing centre at the John Smith's Stadium, home to Huddersfield's football and rugby sides, opened on 1st February 2021.

The solution

The council has a team of drivers – staff who have been redeployed from outdoor education services – who can pick up patients, while support is also provided by the Denby Dale Centre, a charity that works with people who have dementia. Transportation has been provided to 114 patients. Carol Gilchrist, Head of Local Integrated Partnerships, said: "The people getting vaccinated first can be quite frail. Getting to a centre may not be that easy so we felt it was important to get something in place to support them. They get picked up and driven to the centre and then returned home.

Dr Burhan Ahmed, the clinical director for Greenwood primary care network, said the support provided by the council and volunteers was vital. "Some patients have difficulties accessing the vaccination centre. The transport service is an excellent way of ensuring all patients can access vaccinations and nobody misses out."

People were connected to the transport service in various ways. For example, one elderly person was referred by her GP to Social Prescribing for support to access her vaccination appointment due to her challenging mobility and not having the financial means or support to get there. After initially feeling nervous she was able to have her vaccine and was grateful for the support to access the appointment. This was the first time she had been out since March 2020 and she had been feeling socially isolated.

Working together

The partnership between Kirklees Council and the NHS has been critical in several other ways. The council employs nine social prescribing link workers who are each aligned to one of the primary care networks in the borough. They are now working in the vaccination centres providing a range of support, including carrying out pre-vaccination assessments and monitoring patients afterwards.

Library staff have also been redeployed to provide administrative support and queue busting as well as members of the Community Plus team, who are also supporting with the transport, patient safety checks and welcoming patients. More than 30 staff are now helping in some way via mutual aid.

The council, with its close links to the community and voluntary sector, has also been able to recruit volunteers to help manage queues. A system has now been set up which means when GP practices book patients in for the vaccination they ask them if they are able to get to the centre. If they cannot, their details are passed on to the council.

Planning and Estates

Birmingham: Regeneration around Midland Metropolitan and City Hospitals

The new Midland Metropolitan Hospital is at the heart of ambitious plans to regenerate Sandwell in the West Midlands. The scheme, which will bring investment of hundreds of millions of pounds into the area, has brought together the NHS, local councils and voluntary organisations to create opportunities for new housing, employment, education and sustainable transport.

Sandwell and West Birmingham Hospital Trust is working in partnership with Sandwell Metropolitan Borough Council and Birmingham City Council, together with business and voluntary organisations to maximise the regeneration potential. The partnership also includes Aston and Wolverhampton universities.

The vision for this area and its communities is one of raised aspirations, inclusive growth, sustainable economic regeneration, wealth and health. A strong masterplan, combined with the significant investment in the NHS, colleges and universities, canals and green spaces, will attract private investment and will accelerate the post pandemic recovery of the area.

The challenge

Sandwell is one of the most deprived boroughs in England. More than 25% of children live in low-income families. Life expectancy is 8.6 years lower for men and 8.0 years lower for women in the most deprived areas of Sandwell than in the least deprived areas. The area has been hard hit by the economic impact of COVID-19 and unemployment is now around 10%. There is a shortage of affordable housing.

The opportunity

The new Midland Metropolitan Hospital in Smethwick, currently under construction at a cost of more than £400m, is the catalyst for the regeneration of the wider area.

When it is operational next year the 670-bed hospital will provide state-of-the-art treatment and care for patients from Sandwell and across the region. The hospital is built over 16 acres with approximately 80,000 square metres of floor space. It is located just 15 minutes on foot from the existing City Hospital, connected by the historic Birmingham Main Line Canal.

Together the two hospitals are key elements of the Smethwick to Birmingham Corridor Development Framework and Grove Lane Masterplan currently being proposed by Birmingham Council and Sandwell Council.

Sustainability

By working together, the partners have been able to secure funding from multiple sources to accelerate the development of the regeneration project. In addition to the £400m cost of the new Midland Met Hospital, the project has been boosted by Sandwell's successful bids to the Government's Towns Fund, which will bring £67.5m for regeneration schemes in Smethwick, Rowley Regis and West Bromwich. Agreement has been reached with Homes England for 750 homes on the City Hospital site.

Other opportunities include a learning campus at Midland Met in partnership with Aston and Wolverhampton universities and Sandwell College, concentrating health education and training around a major hospital.

Working in partnership with the Canal and River Trust, regeneration partners are exploring the possible reopening of the Cape Arm junction of the Birmingham Canal to create a marina with waterside homes.

The developments will maximise the use of green spaces, promoting health and wellbeing, and explore opportunities for renewable energy and district heating schemes, helping to tackle fuel poverty.

The future

Regeneration projects linked to Midland Metropolitan Hospital are expected to be mostly completed with five years, bringing investment of more than £1.5bn to the area.

Learning Disability – integrated commissioning

Harrow: Co-Located All Age Disability Service for Health, Social Care and Education

In Harrow, the local authority, the NHS and voluntary organisations have come together to improve care and support of people with a learning disability (LD).

Central and North West London NHS Foundation Trust and Harrow Council have created the Community Learning Disability Team to deliver a multi-disciplinary approach to supporting learning disabled adults to live as well and as independently as possible, within the community, with improved life outcomes. It has been co-located with children's social care and education services in purpose-designed premises to improve outcomes for residents of all ages with disabilities.

The team consists of a consultant psychiatrist, specialist registrar, nurses, psychologists, social workers, care managers, a behavioural therapist, a speech and language therapist, physiotherapist, sexual therapist, an occupational therapist, a receptionist, a medical secretary, administrator, business support and managers.

The project is jointly managed by Harrow Council, Harrow CCG, and Central and North West London NHS Foundation Trust in partnership with Harrow Mencap and learning disability self-advocates.

The challenge

Adults with learning disabilities have unique long-term needs and often require support from both social care and health professionals. The desirability of integrated working has been well-documented nationally; for example, in NHS England's national plan and service model for learning disabled people of 2015. In September 2018, Harrow Council created a Specialist LD team for adults to supplement an existing Children and Young Adults with Disabilities team (CYAD) under the same Head of Service, including the Transitions staff.

The NHS adults team worked with over 18s, but on the council side 18 to 25-year -olds are supported through the Transitions team, which was already part of CYAD. One challenge was to co-locate 110 staff, along with appropriate governance for the multiple organisations involved and without an increase to existing budgets.

The solution

Effective governance was established initially through the Health and Wellbeing Board (HWB) executive officers meeting with the CCG and then a tri-partite dedicated project board with the chair rotating between senior managers of the council, the CCG and the NHS Trust. The project also reported to the full HWB chaired by the Leader of the Council. This paid dividends when it was necessary to refurbish offices and establish capital funding which would be recovered through reductions in future rental costs.

A change management process to establish a shared culture of a common purpose in service of people with a learning disability was a key part of the project, with two full day "Purpose Mapping" workshops for mixed staff groups in May 2019. A further session was held with all 45 staff from the joint LD teams closer to the December go-live date. This enabled all staff to get to know each other better, including understanding different professional roles and reviewing a new integrated care pathway. The new pathway was co-produced with service users and carers with input from Harrow Mencap.

The outcome

Locating education, health and social care professionals in the same office space, working together to support children, young people, and adults from birth onwards, and their families and carers, makes it possible to provide a seamless, multifaceted service. The right help will be provided at the right time and in the right place.

The presence of education professionals is raising the profile of this aspect of the child or young person's life, which will contribute to the whole person, whole family approach. The co-location of key services supports a collaborative approach to the development of education, health and care plans to age 25, and a more efficient resolution when there are specific challenges. The co-location of critical services is also supporting the council's Special Educational Needs and Disabilities strategy, which aims to ensure that more children and young people are supported at home and in local educational provision.

Longer-serving staff remember when there used to be an integrated LD team some years ago and were pleased to be returning to that arrangement. For newer staff, the benefits of integration and co-location became clear to them in the culture change workshops. The culture of more integrated and holistic working will be reinforced through team managers and a review of the pathway after six months.

It is expected that the advantages of co-location will lead to better outcomes, greater staff satisfaction and reduced long-term costs, making the initiative self-sustaining. An evaluation model using data from all three parties has been designed to ensure that financial and non-financial benefits are achieved.

Conclusion

Collaboration with local authorities and wider partners is essential for ICSs to be able to drive meaningful improvements in health and wellbeing and enhance the experience and access for service users.

The examples in this report show what can be achieved through place-based partnerships, bringing together a range of partners – including local government, NHS, social care, voluntary and community organisation, housing and others – to join up the planning, commissioning and delivery of services through a multi-agency approach.

It is clear much of the work involved in integrating care and improving population health is driven through these local partnerships. The examples in this resource help to demonstrate the scope of opportunity for partners, through ICSs, to address the social, economic, and wider health needs of their population and deliver positive change.

A key challenge for ICSs and partners alike will be to drive these improvements whilr dealing with the recovery from the Covid-19 pandemic. But by working together ICSs and the place-based partnerships can play a critical role in these efforts, particularly in tackling the health inequalities exposed and exacerbated by the pandemic.

More information about ICSs and case studies are available at:
https://www.england.nhs.uk/integratedcare/.

Further reading and resources:

Thriving places: guidance on the formation, leadership and governance of place-based partnerships within Integrated Care Systems (NHS England and NHS Improvement, September 2021)

Next steps to building strong and effective integrated care systems across England (NHS England and NHS Improvement, November 2020)

Integration and Innovation: working together to improve health and social care for all (White Paper, Department of Health and Social Care, February 2021)

Developing place-based partnerships: The foundation of effective integrated care systems (The Kings Fund, April 2021)

Social Care Institute for Excellence information, support and webinars on integration: www.scie.org.uk/integrated-care

SOLACE Health and Social Care Virtual learning: https://solace.org.uk/health-and-social-care/

Achieving integrated care: 15 best practice actions (Local Government Association, November 2019)

Shifting the centre of gravity: making place-based, person-centred health and care a reality (Local Government Association, November 2018)