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Thriving places

Guidance on the development of place-based partnerships as part of statutory integrated care systems

NHS England and NHS Improvement may update or supplement this document during 2021/22. Elements of this guidance are subject to change until the legislation passes through Parliament and receives Royal Assent. We also welcome feedback from system and stakeholders to help us continually improve our guidance and learn from implementation. The latest versions of all NHS England and NHS Improvement guidance relating to the development of ICSs can be found at ICS Guidance.

Version 1, 2 September 2021

ICS implementation guidance

Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined-up services and to improve the health of people who live and work in their area.

They exist to achieve four aims:

- **improve outcomes** in population health and healthcare
- **tackle inequalities** in outcomes, experience and access
- enhance **productivity and value for money**
- help the NHS support broader **social and economic development**.

Following several years of locally-led development, and based on the recommendations of NHS England and NHS Improvement, the government has set out plans to put ICSs on a statutory footing.

To support this transition, NHS England and NHS Improvement are publishing guidance and resources, drawing on learning from all over the country.

Our aim is to enable local health and care leaders to build strong and effective ICSs in every part of England.

Collaborating as ICSs will help health and care organisations tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

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About this document

This co-produced NHS England and NHS Improvement and Local Government Association (LGA) document seeks to support all partner organisations in integrated care systems (ICSs) to collectively define their place-based partnership working, and to consider how they will evolve to support the transition to the new statutory ICS arrangements, anticipated from April 2022. It reflects learning to date, and the intention is to support partners to build on existing arrangements, not to disregard partnership approaches that are already working well.

Key points

- Place-based partnerships are collaborative arrangements formed by the organisations responsible for arranging and delivering health and care services in a locality or community.
- Place-based partnerships will remain as the foundations of integrated care systems as they are put on a statutory footing (subject to legislation), building on existing local arrangements and relationships.
- It will be for system partners to determine the footprint for each place-based partnership, the leadership arrangements and what functions it will carry out.
- This document describes the activities placed partnerships may lead, capabilities required and potential governance arrangements.

Action required

- As part of the establishment of new ICS arrangements from April 2021 ICS leaders should confirm their proposed place-based partnership arrangements for 2022/23, including their boundaries, leadership and membership.

Links to other guidance and resources

- ICS design framework,
- Interim guidance on the functions and governance of the expected Integrated Care Partnership (ICP) and Integrated Care Board (ICB)
- Learning from place-based partnerships prepared by Society of Local Authority Chief Executives and Senior Managers (Solace)

Foreword

The health, care and other public and voluntary services people use are predominantly delivered within the community or ‘places’ where they live or work. Almost 80% of people’s interactions with the NHS occur in their own homes, their GP practices, community pharmacies, dentists or local health centres, and the vast majority of social care services is delivered at home or in the community.

Across the country, there is a wide range of place-based partnerships between local government, the NHS, social care providers, the voluntary, community and social enterprise sector and other community partners. Where these arrangements are working well, they provide a strong foundation for ICSs: for co-ordinating and integrating services; embedding co-production with people who use services; facilitating accountability to local communities; and building broader coalitions with community partners to promote health and wellbeing.

As we face the challenge of social, economic and public health recovery from the COVID-19 pandemic and look to tackle the inequalities and vulnerabilities it has exposed, the case for multi-agency working is strong. We know now more than ever the shared strength and resilience of our local communities and the opportunities that utilising and investing in our shared social infrastructure can bring to prevent ill health and promote wellbeing.

If we are serious about promoting better health and wellbeing and addressing health inequalities, we must take collective decisions based on a shared understanding of the local population and how people live their lives. We must look beyond health and care services to the wider determinants that influence the health of our populations – early years support, housing, leisure, transport, skills and education, employment support and the environment.

Cllr David Fothergill
Chairman,
LGA Community Wellbeing Board

Mark Cubbon
Interim Chief Operating Officer
NHS England and NHS Improvement

1. Introduction

Place-based partnerships are collaborative arrangements that have been formed across the country by the organisations responsible for arranging and delivering health and care services in a locality or community. They involve the NHS, local government and providers of health and care services, including the voluntary, community and social enterprise sector (VCSE), people and communities (people who use services, their representatives, carers and local residents). In many cases they include other community partners with a role in supporting the health and wellbeing of the population and addressing health inequalities, such as housing associations, skills and education services and local business.

This guide developed by NHS England and NHS Improvement and the Local Government Association (LGA) seeks to support all partner organisations in integrated care systems (ICSs) to collectively define their place-based partnership working, and to consider how they will evolve to support the transition to the new statutory ICS arrangements, anticipated from April 2022. It reflects learning to date from existing place-based partnerships and summarises the governance arrangements we expect will be available for place-based partnerships following the passage of legislation. The intention is to support partners to build on existing arrangements, not to disregard partnership approaches that are already working well.

It should be read alongside the ICS design framework, Interim guidance on the functions and governance of the Integrated care board (ICB), as well as further guidance on the integrated care partnership (ICP) due to be published by the Department of Health and Social Care (DHSC), the LGA and NHS England and NHS Improvement. In addition, NHS England and NHS Improvement have published learning from place-based partnerships prepared by the Society of Local Authority Chief Executives and Senior Managers (Solace), and further examples of learning about collaboration between health and care partners at place are included in Annex 1.

Background

There is a long history of partners developing collaborative approaches to jointly plan and deliver health, social care and public health services alongside other services

that promote health and wellbeing in a defined place. Currently, health and wellbeing boards (HWBs) provide a shared vehicle for political, clinical, professional and community leaders of a place to develop a shared ambition for improving health and wellbeing and addressing health inequalities. This is undertaken through joint strategic needs assessments (JSNAs) and the agreement of a joint health and wellbeing strategy (JHWS) for a place, which clinical commissioning groups (CCGs) must take into account in developing their commissioning plans. In many areas, place-based partnership arrangements go beyond strategic planning and include shared leadership roles, joint commissioning between local authorities and the NHS, and integrated service delivery by a range of providers.

To date, place-based partnerships have been established by local agreement according to their context. This flexible, bottom-up approach is an important enabler for meaningful collaboration. As part of the development of ICSs, there is an expectation that partnerships at place level will play a central role in planning and improving health and care services, proactively identifying and responding to population need. Place-based partnerships also provide an opportunity for the organisations responsible for planning and delivering these services to continue to build and maintain broader coalitions with community partners to promote health and wellbeing, influencing the wider determinants of health.

Transitioning to statutory ICS arrangements

In February 2020 the Government published its White Paper in advance of the Health and Social Care Bill, Integration and innovation: working together to improve health and social care for all. Subject to the passage of legislation, ICSs will include the following statutory entities at system-level:

- an integrated care partnership (ICP), the broad alliance of organisations and representatives concerned with improving care and the health and wellbeing of the population, jointly convened by local authorities and the NHS
- an integrated care board (ICB), bringing the NHS together locally to improve population health and care.

The White Paper also emphasised the important role of place-based partnerships to support joint-working between the NHS, local government and other partners in sub-system localities, as well as the opportunity for a significant amount of system decision-making at place-level where appropriate. The Bill does not set out fixed

arrangements for the governance of place-based partnerships; instead it gives flexibility for partners to agree how they work locally.

As part of the development of ICSs during 2021/22, NHS England and NHS Improvement asked ICSs to confirm their initial proposals for place-based arrangements for 2022/23 onwards.[1] These arrangements should be mutually agreed between the NHS, local government and other system partners, and refined as needed throughout the year and beyond to reflect the development of working relationships. They should set out:

- the configuration, size and boundaries of the ICS's places
- the system responsibilities and functions to be carried out at place level
- the planned governance model, including membership, decision-making arrangements, leadership roles as well as agreed representation on, and reporting relationships with, the ICP and ICB.

In June 2021, NHS England and NHS Improvement published the ICS design framework. This describes current expectations for how the ICB and other NHS partners will work with local government and system partners as part of new statutory ICS arrangements. The ICS design framework also described the role of at-scale provider collaboratives, bringing providers together across multiple places to deliver benefits of mutual aid and working at scale, with place-based partnerships co-ordinating the planning and delivery of integrated services within localities and alongside communities. To deliver their objectives, place-based partnerships may consider different approaches for providers from different sectors to work together to co-ordinate care and integrate services in their locality, though this will be distinct from the role of the at-scale provider collaboratives described in NHS England and NHS Improvement guidance on provider collaboratives. In chapter 3, we describe how place-based partnerships may work together with system partners to agree ICS priorities and to inform the priorities of provider collaboratives. We recognise some providers will be members of an at-scale provider collaborative and one or more place-based partnerships. Providers should work with place-based partnerships to ensure their role in the partnership is clearly defined and to avoid duplication or conflict between these collaborative arrangements.

[1] NHS operational planning and contracting guidance for 2021/22

This document supports ICS partner organisations to develop their plans for working in place-based partnerships as part of future statutory ICS arrangements, drawing on the learning from effective place-based partnerships to date.

NHS England and NHS Improvement and the LGA may update or supplement this document during 2021/22. Elements of this guidance are subject to change until the legislation receives Royal Assent.

We also welcome feedback from systems and stakeholders to help us continually improve our guidance and learn from implementation. All the latest NHS England and NHS Improvement ICS guidance can be found at:
https://www.england.nhs.uk/integratedcare/resources/key-documents/ and
https://future.nhs.uk/ICSGuidance/grouphome.

2. Defining place within the health and care system

What have we asked of ICSs?

The NHS, local government and other local partners should agree the configuration, size and boundaries of the ICS's places from April 2022.

Guiding principles

Our learning from across the country has highlighted principles for partners at place to consider as they build on their existing arrangements over the forthcoming year:

- There is no single approach to defining how, and at what scale, partners should come together to work in an ICS. Place-based partnerships should start from understanding people and communities and **agreeing shared purpose before defining structures**.
- Effective partnerships are often **built 'by doing'** – acting together and building collaborative arrangements to support this action as it evolves.
- Governance arrangements must **develop over time**, with the potential to develop into more formal arrangements as working relationships and trust increase.
- Partnerships should be built on an ethos of **equal partnership** across sectors, organisations, professionals and communities.
- Partners should consider how they develop the **culture and behaviours** that reflect their shared values and sustain open, respectful and trusting working relationships supported by clearly defined mechanisms to support public accountability and transparency.

Some of the resources in Annex 1 identify other important principles and learning in establishing and maintaining partnerships at place.

Defining the geography of place

As far as possible, the footprint of place should be based on what is meaningful to local people, has a coherent identity and is where they live their lives – such as a town, city, borough or county. The footprint for place-based partnerships must be defined collaboratively, to ensure that it is a meaningful forum for engaging partners to deliver joint actions. The LGA et al in Shifting the centre of gravity recommend:

> *"Place-based systems should be established or amended following local discussion and considering the role of all the partners who contribute to health and care in a place, including housing, employment and training, and emergency services."*

Considerations when defining the geography of place

Local authority areas are well understood by local communities.

- Adults' and children's social care, public health, community and voluntary services and many other local services that influence health and wellbeing are planned and delivered across local authority footprints.
- Places can be formed around councils with adults' and children's social care responsibilities or district councils.
- In two-tier areas, the county council and ICS may be co-terminous and the places within the county are defined by the boundaries of one or multiple district councils.
- Partners should consider where local government services are planned and what that means for the joint-working opportunities at different parts of the system.

While many NHS services are also oriented around communities, they may not always have a consistent geographical catchment area. In considering place-level footprints:

- System partners should consider how primary care networks (PCNs) and other community-based health services at neighbourhood level are organised.

- They should also consider how local people use NHS services; and relationships between services established through clinical networks, care pathways or training and education provision.

There are other contextual factors partners may wish to consider when defining their place:

- geographical features or infrastructure that influence the way people use services
- existing partnership arrangements and governance structures where they are working well to avoid duplication or unnecessary disruption
- where ICS areas contain more than one local authority and HWB, it may make sense for the local authority and HWB footprints to act as the basis for place-based partnerships
- where an ICS and HWB are co-terminous, the ICS may choose to use the HWB as part of its system governance, and to establish separate place-level governance arrangements where appropriate.

The variation in the size of ICSs, as well as their geography and provider landscapes, mean it is important for system partners to agree locally on the scale of system functions, capabilities and activities. It is expected that places will be wholly within one system's boundaries to ensure efficient and effective local decision-making and clear accountability for resources. While system and place are common constructs for describing the architecture of an ICS, in some smaller systems the system and place may be co-terminous. Elsewhere, some NHS decision-making forums and capabilities have been established on a footprint that sits between the place and whole ICS geography to co-ordinate planning at an appropriate scale. System partners should seek to establish arrangements through mutual agreements that are coherent and well understood in their context.

3. Defining the purpose and role of the place-based partnership

What have we asked of ICSs?

The NHS, local government and other local partners should agree the ICS responsibilities and functions to be carried out at place level.

People will access most of the health and care services they use in the 'place' in which they live, including advice and support to stay well and access to joined-up treatment when they need it. Partners in place should ensure they have shared objectives, built on a mutual understanding of the population and a shared vision for the place. The vision for places should focus on improving the health and wellbeing outcomes for the population, preventing ill health and addressing health inequalities. The objectives places agree to support this vision may orient around different goals related to improving the quality, co-ordination and accessibility of health and care services to better meet the needs of people and communities, and to build coalitions across a range of community partners. These objectives should reflect the priorities that are most important to their partnership and to their communities.

The shared objectives of partners at place should underpin the purpose and role of the partnership. This will comprise the actions the partnership will undertake together, and the capabilities required to support this. This may include the statutory functions delivered by bodies in the partnership (see chapter 4), individually or jointly, as well as the supporting programmes and activities that will support the partnership to achieve its objectives with the resources available.

Agreeing the shared capabilities and activities of the partnership

Table 1 summarises some of the programmes and activities that place-based partnerships may undertake together, based on the existing progress of places. These may be underpinned by shared functions or capabilities, such as people, digital and technology functions, business intelligence and analytics. They should always be supported by an approach to working that embeds systematic involvement

of relevant professional groups, service users, carers and communities, described further in chapter 4.

The place-based partnership may agree that these capabilities and activities should be led by individual organisations or resourced collaboratively by programmes delivered across organisational boundaries. It is most important that the partnership helps organisations to agree where capabilities and programmes should sit to avoid conflicting activities or duplicated effort. They may also use this as an opportunity to consider how they will support the continued development and capability of the place's professional communities to meet the future work of the partnership.

Place-based partnerships should work with other partners across the ICS to agree the activities and capabilities that may be most effectively delivered at scale across the system, or where a consistent approach across places is appropriate. This should draw on local knowledge and learning, and the peer review approaches used in local government can be usefully applied between places.

As part of this, place-based partnerships will have a role to agree the shared priorities of the wider system, which will include working with at-scale provider collaboratives, where they have taken on responsibility for the delivery of certain services at-scale, to ensure this meets the needs of communities in their place and to avoid the duplication of activities. NHS England and NHS Improvement have published further guidance on the development of at-scale provider collaboratives.

Place-based partnerships may also consider different approaches to take locally to support providers of different types and from different sectors to work together to co-ordinate care and integrate services in their locality, though this will be distinct from the role of the at-scale provider collaboratives described above. There are a wide range of approaches to support provider and professional collaboration in a place that have been explored to date, including formal models of contractual integration for specific sets of services (eg lead provider models who take on responsibility for delivering a set of services) or more informal arrangements to support co-ordination between professionals (eg multidisciplinary teams). NHS England and NHS Improvement and partners will continue to support systems and providers to explore appropriate models for collaboration in any new legislative framework.

Some ICSs have undertaken functional review processes to help them agree the division of responsibilities across their whole system. This involves establishing ways of working, values, purpose and design principles before agreeing their precise functions and responsibilities.

Example

During their functional review, **Sussex ICS** used three design principles to consider its choices in where to host responsibilities:

1. Do we need a critical mass beyond the local level to deliver the safe and sustainable services which achieve the best outcomes?
2. Will working together achieve greater effectiveness in improving health and care outcomes for all in line with the long-term plan?
3. Does the plan align with the overall ICS design principles and move to ICS assurance and oversight models?

Table 1: Potential activities and approaches of place-based partnerships

Health and care strategy and planning at place	The place-based partnership has a common understanding of its population, and has agreed a shared vision, including local priorities for the delivery of health, social care and public health services in the place. The place vision and local priorities are developed in response to the needs of communities at neighbourhood and place. They build on existing plans already agreed where relevant, such as JHWS, drawing on insights from JSNAs, and engage different types of professionals to ensure it resonates with frontline staff and communities. Building on its vision and local priorities, the place-based partnership will have a role in informing and developing the integrated care strategy agreed by all partners in the ICP, which will also consider system-wide priorities, and inform the NHS plan developed by the ICB, which will also include national NHS transformation commitments. Partners at place will also be responsible for delivering these system-wide plans where relevant.

Service planning	The place-based partnership has agreed approaches to align the commissioning of NHS and local government services around shared objectives and outcomes, involving relevant partners, people and communities. Where agreed locally, this includes formal joint commissioning arrangements, where NHS and local authority budgets are delegated to a shared decision-making structure and planning decisions are made via a single process. The place-based partnership may look to providers of health and social care to play an active role in parts of the commissioning process. In particular, place-based partners should consider approaches to collaboratively monitor the delivery of services as part of the planning cycle, including quality monitoring, reviewing performance and outcomes, and workforce planning.
Service delivery and transformation	The place-based partnership continues to integrate and co-ordinate the delivery of health, social care and public health services around the needs of the population, and to empower people who use services (including supporting the adoption of Personal Health Budgets). It is important that each place-based partnership fosters a culture of innovation, enabling the sharing of best practice between organisations, and promoting adoption of proven innovation. For example, this includes PCNs working with other providers (including social care) as part of integrated multidisciplinary teams between professional groups to co-ordinate care for people with more complex conditions or support needs, drawing on analytical support to identify needs. It also includes fostering closer working between sectors to ensure that transitions in care are managed effectively and issues are resolved; for example, managing discharge between secondary care to community services, adult social care or primary care.

Population health management	The place-based partnership has agreed with wider system partners plans to establish population health intelligence and analytical capabilities at-scale, as well as approaches to draw on this insight to support care redesign locally, building on existing expertise across the place and system. This is a key component of a quality improvement strategy, prevention and approach to addressing health inequalities. This typically includes segmentation and modelling to understand future demand across different population groups and care settings, working with PCNs and other partners to understand their population's bio-psycho-social risk factors, and supporting the implementation of anticipatory care models. NHS England and NHS Improvement intend to develop materials on the different approaches to sharing resources that can support care model redesign, and already hosts a series of resources to support population health management approaches on the PHM online academy.
Connect support in the community	The place-based partnership works with a wide range of community partners to leverage and invest in community assets and support for improved wellbeing. For example, national support for social prescribing link workers in PCNs provides new opportunities to connect service users to a broader range of health and wellbeing support in the community. Partnerships should work with voluntary, community and social enterprise (VCSE) sector partners to understand where there are opportunities to develop service provision to support communities to build resilience and independence. This may also include working with community partners to influence health and wellbeing in the community, including housing associations, education providers and local businesses.

Promote health and wellbeing	The place-based partnership proactively works with local agencies and community partners to influence the wider determinants of health and wellbeing, and to support other local objectives such as economic development and environmental sustainability. This may include aligning plans with public health and other local government strategies and plans. This could include improving the quality of housing and the built environment, skills development and employment support services, promoting active transport and improving the natural environment and air quality. The NHS and local government may consider opportunities to leverage their role as 'anchor institutions' to support economic opportunity and skills development in their communities, building on existing research.[2]
Align management support	Place-based partners agree options to align and share resources. For example, some places have arranged operational support to PCNs, including population health data and analytics to support the co-ordination of care, as well as HR support or programme management. The PCN clinical directors in a defined place should be supported to build their working relationships over time to be able to drive improvement through peer support, lead on service transformation programmes and represent primary care in the place-based partnership.

[2] Find out more from the Health Anchors Learning Network, facilitated by The Health Foundation and Innovation Unit in partnership with NHS England and NHS Improvement .

4. Governance, decision-making and accountability

What have we asked of ICSs?

The NHS, local government and other local partners should agree the planned governance model for place including:

- membership
- place-level decision-making arrangements, including any joint arrangements for statutory decision-making functions between the NHS and local government
- leadership roles, for convening the place-based partnership, as well as any individuals responsible for delegated functions
- representation on, and reporting relationships with, the ICP and ICB.

Membership

While it will be for local partners to agree the appropriate organisations and individuals to be included in the place-based partnership arrangements, they will do well to consider how they will include representation from the following:

- primary care provider leadership, represented by PCN clinical directors or other relevant primary care leaders
- providers of acute, community and mental health services, including representatives of provider collaboratives where appropriate
- people who use care and support services and their representatives including Healthwatch
- local authorities, including Directors of Adult Social Services and Directors of Public Health and elected members
- social care providers
- the voluntary, community and social enterprise sector (VCSE)
- the ICB.

The place-based partnership should agree which other community partners with an important voice or role should be involved in the partnership, as members of committees or through other working groups and arrangements. This will depend on the objectives of the partnership, and may include housing associations, emergency services, prisons, universities and education providers. There will be partners with more complex footprints, such as ambulance trusts, which depending on the nature of working relationships, may be most appropriately represented as members or through other working arrangements, which should be agreed.

In preparing for new statutory ICS arrangements for 2022/23 onwards, consideration may be given about how best to engage the clinical and professional leadership of existing NHS CCGs to support transition, and the ongoing development of the partnership.

Working with people and communities

As part of their decision-making arrangements, place-based partnerships should systematically involve professionals, people and communities in their programmes of work and decision-making processes. This should build on existing approaches to engaging and co-producing with people and communities; for example, those approaches developed by HWBs.

These arrangements should be a source of genuine co-production and a key tool for supporting accountability and transparency of the system. They should establish a shared understanding of the community's needs, build relationships with all communities, including excluded groups and those affected by inequalities in access or outcomes, and use continued engagement to measure if partners are improving people's experiences of care and support. They may also include supporting PCNs and neighbourhood teams to work with people and communities to strengthen health promotion and treatment.

Where decision-making affects communities, groups or specific services, these arrangements (including any formal consultation) should fully engage those affected, including populations, people who use services and carers across health and social care. Partners should ensure they provide clear and accessible public information about the vision, plans and progress of the place-based partnership to build understanding and trust, and to start engagement early when developing

plans and feed back to people and communities how their views have influenced activities and decisions.

The statutory bodies in place-based partnerships are responsible for ensuring that decision-making meets their responsibilities under the Equality Act 2010, including completing equality impact assessments where appropriate. NHS England and NHS Improvement will update current guidance for NHS commissioners on their legal duties regarding equality and to reducing health inequalities.

NHS England and NHS Improvement are providing further guidance on working with people and communities, which includes overarching principles, specific recommendations for building on and advancing arrangements at place as well as expectations for approaches to working with Healthwatch and the VCSE sector.

Agreeing the functions of the place-based partnership

The leaders of the ICP and place-based partners should engage in a process of agreeing the responsibilities and governance arrangements of place-based partnerships, in the context of the proposals for the new statutory ICS entities. We expect the allocation of decision-making functions between system and place will vary across the country and should be shaped through collaborative discussions. Leaders from across the ICS will need to consider how the combined governance arrangements at all levels of the ICS avoid duplication or conflicts in decision-making, are proportionate and support the aims of partnership.

The considerations of what is undertaken at system or place should be guided by the principle of subsidiarity, with decisions taken as close to local communities as possible, and at a larger scale where there are demonstrable benefits or where co-ordination across places adds value. We expect that the leadership of the ICP will focus on leading activities where there is a need to work across a larger population to address systemic issues; for example, taking action to reduce unwarranted variation or realising advantages of scale. They should also consider how they support place-based partnerships, and how they ensure appropriate resource, capability and delegated decision-making are established at place. Partners at place should consider how they work as part of the ICS governance to support decision-making at scale, including making decisions with at-scale provider collaboratives.

Where place-based partnerships agree with statutory bodies – for example, the ICB, NHS providers or local government – to take on delegated statutory functions for the place, the relevant bodies will retain accountability for these functions and must be satisfied the place-based partnership is able to manage the functions appropriately. They will agree with the partnership any terms of the delegation including the governance and assurance arrangements required to ensure the functions are delivered in a proper way. The delegated functions must be exercised in accordance with the duties of the delegating body. In the case of the delegation of functions from the ICB, this will be in adherence with the constitution and schemes of reservation and delegation, as well as being agreed by the ICB. NHS England and NHS Improvement have provided further guidance on the functions and governance of the ICB as well as a model constitution.

The place-based partnership will need to play a major role in the delivery of national expectations attached to NHS funding, including transformation commitments in the NHS Long Term Plan and funding commitments such as the Mental Health Investment Standard. Place-based leaders from all partner organisations should consider how they will develop and agree plans that deliver national NHS commitments as well as local priorities, whether specific to their locality or agreed with wider system partners.

Governance and decision-making arrangements

To date, place-based governance arrangements in ICSs have been informal forums for consultation and co-operation, where agreed actions are subsequently enacted through other governance arrangements. In some places, the HWB has provided a forum to align decision-making between local government and NHS partners. Section 75 partnership agreements are used to enable joint decision-making between local authorities, NHS CCGs or providers for the commissioning of health or social care services. Local areas must also consider how to balance and build on existing relationships and governance arrangements, with the delivery of the functions and duties set out in the proposed legislation. For example, HWBs will have specific requirements set out in legislation in relation to fulfilling duties of the ICB.

Table 2 summarises the broad types of governance arrangements that could be established to support place-based partnerships to make decisions between the

appropriate partners, if the Bill is passed in its current form. Further consideration will need to be given to the decision-making arrangements of committees and agreed with statutory bodies where they relate to the delegation of statutory functions; for example, agreeing the approaches to managing disagreement in their terms of reference and whether a lead member of a committee is required.

Some of the arrangements described below may be implemented through existing arrangements, such as HWBs. However, there may be some arrangements that must be established independently. The arrangements are not mutually exclusive, and places may adapt and revise the below arrangements to address their particular business and decision-making needs. It is also possible to use a single forum for multiple purposes. Place-based partnerships should consider, along with wider system partners, how they will ensure governance and decision-making remains clear and proportionate and avoids duplication across the ICS, and how they share information and involve partners to promote joined-up decision-making.

Place partners should agree the membership of the different parts of their governance arrangements, recognising the different role partners will play, and that it may not be considered appropriate for some members of the place-based partnership to participate in some formal decision-making arrangements.

The shared decision-making arrangements agreed by place-based partners depend on continued mutual co-operation and agreement between partners, where all parties have trust and confidence in the arrangements. It is crucial therefore that the partnership has agreed ways of managing disagreement and maintains a strong focus on organisational and cultural development and ways of working to ensure that trust, transparency and co-operation can be maintained. We recognise places will be at different stages of working together and should consider how they transition to arrangements iteratively over time to support the development of the partnership.

Table 2: Governance approaches for place-based partnerships

Approach	Considerations
Consultative forum A collaborative forum to inform and align decisions by relevant statutory bodies, such as the ICB or local authorities, in an advisory role. In this arrangement, the decisions of statutory bodies should be informed by the consultative forum.	• Helpful for engaging the widest range of partners to discuss and agree shared strategic direction together. Many places have found it useful to establish forums for developing shared visions and priority setting. • One current option is HWBs, which are a collaborative body bringing together the clinical, professional, political and community leadership. Other local areas have established place boards to fulfil this consultative forum function.
Individual executives or staff Statutory bodies may agree to delegate functions to individual members of staff to exercise delegated functions, and they may convene a committee to support them, with membership that includes representatives from other organisations.	• Helpful for engaging partners in the decision-making of statutory bodies, while retaining a single SRO for decisions. • A named individual could become the SRO for the place in their body, enabling budgets to be defined for the committee and managed through their internal management and reporting arrangements. In addition to the decision-makers, there can also be individuals in attendance who do not have decision-making authority but can participate in the discussion in the forum setting. • Equally, the individual director could be a joint appointment, between the ICB and local authority, or statutory NHS provider, and may have delegated authority from those bodies.
Committee of a statutory body A committee provided with delegated authority to make decisions about the use of resources. The terms of references and scope are set by the statutory body and agreed to by the	• Helpful for making decisions based on a range of views, while facilitating delegated authority for the use of resources. • For a committee of the ICB or LA, in both instances, there is an expectation that there

committee members. A delegated budget can be set to describe the level of resources available to cover the remit of the committee.

are joint working arrangements with partners to embed collaboration.

- The committee may appoint representatives of non-statutory providers to participate in the committee or attend meetings to take part in discussions without being members, but only where the convening statutory bodies consider it appropriate.
- HWBs are constituted as committees of local authorities and are charged with promoting greater integration and partnership between bodies from the NHS, public health and local government, and can also exercise functions delegated to them by their local authority.

Joint committee

A committee established between partner organisations, such as the ICB, local authorities, statutory NHS providers or NHS England and NHS Improvement. The relevant statutory bodies can agree to delegate defined decision-making functions to the joint committee in accordance with their respective schemes of delegation. A budget may be defined by the bodies delegating statutory functions to the joint committee, to provide visibility of the resources available to deliver the committee's remit.

- Helpful for making joint decisions between relevant partners.
- The committee may include participation from representatives of non-statutory providers, but only where the convening statutory bodies consider it appropriate.
- To date, we have seen that NHS and/or local government functions can be integrated using S.75 (of the NHS Act 2006) arrangements, creating a Joint Committee to manage the arrangements. Equally, section 65Z5 of the 2006 Act, inserted by clause 60 of the Health and Care Bill, allows the setting up of joint committees between a LA and an ICB.

Lead provider

A lead provider manages resources and delivery at place-level, as part

- Helpful for giving provider leaders greater ownership and direction around the delivery and co-ordination of services.

of a provider partnership, under a contract with the ICB and/or local government, having lead responsibility for delivering the agreed outcomes for the place (including national standards and priorities) for the defined set of services.

- The lead provider would subcontract other providers within the scope of the place-based delivery partnership. They can agree how resources are spent within the payment envelope agreed with the statutory body, complying with the terms of the contract, and establish governance with partnering providers to support delivery.
- The Integrated Care Provider (ICP) Contract is one of the available options for systems to enable joined-up decision-making and integration of services. It will enable a single contract to be awarded to a provider that is responsible for the integrated provision of general practice, wider NHS and potentially local authority services.

Further interim guidance is available on the functions and governance of the ICB, including technical guidance materials to support the delegation of statutory functions from local government or the NHS to place-based partnerships, where agreed locally.

We expect statutory bodies may set a budget for place-based partnerships to support local financial decisions, where it has agreed with the place-based partnership to delegate decision-making functions to the partnership. When taking responsibilities for NHS funding from the ICB, place-based partnerships must adopt the principle of equal access for equal need and the requirements to reduce health inequalities, as well as supporting transparency on the spending made at place level. The ICB should explain any variation from previous CCG budgets and enable the shared planning or pooling of NHS and local authority budgets, including stated minimum NHS contributions to Better Care Fund arrangements.

Some consistent components of effective governance, decision-making and reporting have been included in NHS England and NHS Improvement guidance on the functions and governance of the ICB. The LGA and NHS Clinical Commissioners have also published a resource to support localised decision-

making, including 10 key lines of enquiry to consider how decision-making is working locally. This and other helpful resources have been included in Annex 1.

Accountability arrangements

Place-based partnerships bring together local government, NHS and other partners, each with distinct governing body arrangements and accountabilities. While NHS partners will be accountable for delivery of their functions through NHS England and NHS Improvement and to central government, local authority partners are accountable to communities through local democracy. Place-based partnerships should agree the arrangements required to fulfil each of these relationships appropriately, including how they engage council elected members or NHS non-executive directors in decision-making, as well as their relationships with HWBs and local authority health overview and scrutiny arrangements, and the relationship between NHS bodies and NHS England and NHS Improvement .

NHS England and NHS Improvement recently published the NHS System Oversight Framework for 2021/22, with an increasing focus on overseeing system performance. The oversight framework for the NHS will develop further in future years to support implementation of future statutory arrangements for ICSs. We expect this will include NHS England and NHS Improvement working with the ICB to understand and manage the performance of individual NHS organisations, with NHS England and NHS Improvement maintaining formal responsibility for the oversight of NHS providers. The place-based partnership and ICB leadership should consider and define the role the place-based partnership and its leadership team will play to support effective monitoring of performance within the system, sharing data and intelligence across partners, identifying risks and helping to agree remedial actions – particularly in relation to any statutory functions have been delegated to the place-based partnership.

To support joint working, place-based partnerships should embed the principle of mutual accountability, where all partners, irrespective of their own formal accountability relationships, consider themselves mutually accountable to each other and to the population and communities they serve, even where not underpinned in formal arrangements. This is important to ensure there is collective ownership of the partnership’s vision, priorities, plans and delivery, and the co-operation required to deliver this.

5. Leadership

Leadership roles

There is a range of leadership roles that may be fulfilled at place, and they will depend on the responsibilities the place-based partnership has agreed to undertake together. Partnerships may choose to have an overall lead for the place, its vision and plan, which will likely comprise the role of convening the partnership but may also include responsibility for managing delegated statutory functions. This will typically be accompanied by other leadership roles in the partnership for defined functions or programmes of work. The roles and responsibilities of the leadership team will typically fall into the three broad categories described in **Table 3**.

Table 3: Leadership roles in place-based partnerships

Role	Description
Partnership convenor Support the convening of the place-based partnership and facilitate the development of its ways of working.	A leader whose role is to convene the place-based partnership, facilitating priority-setting, strategic alignment and decision-making between organisations across multiple sectors. This role may take the form of a place-based partnership lead or chair, and the leader may represent the partnership in other governance forums; for example, the ICP, the board of the ICB, or HWB where separate.
Executive leads Take formal responsibility for statutory functions delegated to the place-based partnership.	Leaders who are appointed to take on responsibility for any decision-making functions delegated by statutory bodies, including any associated financial governance responsibilities. These roles will be fulfilled by employees of the statutory body delegating the function, or jointly appointed where functions are delegated from multiple statutory bodies, and the employee will adhere to the conflict of interest policies of the organisation(s).

Programme leads	
Take a leadership role for co-ordinating a shared function or programme on behalf of the place-based partnership, without formal responsibility for statutory functions.	Leaders who take on responsibility for other shared functions or programmes of work on behalf of the place-based partnership that are not related to formally delegated statutory functions but support the place to achieve its objectives, such as people development, data and analytics. Their responsibilities and reporting arrangements to the place-based partnership should be agreed locally.

In many cases, leaders at place will balance multiple roles in the system. Some place-based partnerships have introduced independent chairs, to help maintain balance in the partnership's agenda between different sectors, and to ensure accountability to local partners and communities.

It is important that the leadership roles of the place-based partnership are agreed and defined clearly, based on the functions and programmes of the partnership, and there is an agreed process to manage any potential conflicts of interest.

Leadership skills and capabilities

Those taking on a leadership role in a place-based partnership will be responsible for bringing together a wide range of perspectives, where mutual respect for different viewpoints and organisational sovereignty is critical to maintaining progress. These leaders will need to use facilitative leadership and personal influence to find a common vision and purpose for the partnership, and to manage disagreement constructively.

It can take time to build these skills and establish the trusting relationships on which collaboration can be built. Places that have invested in this have reaped the benefit. Whilst leaders and teams will clearly want to shape their own development, learning to date suggests the key skills and behaviours that place-based leaders should aspire towards to be effective in their role include:

- openness and honesty with colleagues, as well as acting with integrity
- a commitment to listening to others and understanding different points of view

- strong relationship-building skills, with the capability to work with partners to develop a shared vision around joint priorities and plans
- a readiness to take ownership of complex problems
- curiosity and the ability to understand what is really happening, and not what is supposed to be happening
- encouraging close working between leaders from different organisations to build relationships and solve problems
- fostering a culture of continuous learning, measuring effectiveness and adapting the approach on what is or is not working
- regularly engaging with people who use services, carers and members of the voluntary sector to understand their experiences of care and acting on their views.

There is a range of system leadership programmes on offer to support current and aspiring health and care leaders to develop collaborative leadership skills. The LGA has a range of events, workshops and publications available in its Leading Healthier Places programme. The NHS Leadership Academy has also developed the System Leadership Behaviours toolkit.

6. Conclusion

Place-based partnerships are already seizing opportunities to support people in their communities to live healthier and more fulfilled lives, or the specific arrangements or ways of working that will enable each partnership to develop and thrive. We have therefore not attempted to describe the full range of opportunities as this is something colleagues working in systems and place-based partnerships will work through and agree together locally. There is a limit to how much can be described in guidance, particularly where there is widespread recognition of the variation in approaches being taken across the country, and the need for flexibility to support places to make partnership arrangements work for their context.

We will develop further resources including case studies and in-depth learning on the approaches that partnerships have taken to foster collaborative models of service planning and delivery between partners in different sectors.

We look forward to updating this content as place partnerships adapt to new statutory arrangements and the relationships they build with their communities continue to thrive.

Annex 1: Helpful resources

The King's Fund (April 2021) Developing place-based partnerships

The King's Fund (September 2019) Creating healthy places

Local Government Association (May 2021) Leading Healthier Places 2021/22 - Support for care and health leaders

Local Government Association (July 2019) What a difference a place makes: the growing impact of health and wellbeing boards

Local Government Association, Association of Directors of Adult Social Services, Association of Directors of Public Health, NHS Clinical Commissioners, NHS Confederation, NHS Providers (November 2018) Shifting the centre of gravity: making place-based, person-centred health and care a reality

Local Government Association and NHS Clinical Commissioners (December 2020) Localising decision making: a guide to support effective working across neighbourhood, place and system,

NHS Confederation (May 2021) The role of primary care in integrated care systems

NHS Providers System Transformation Peer Support programme

NHS Providers (June 2021) Collaborating for better care

Social Care Institute for Excellence (SCIE) (November 2018) Leadership in Integrated Care Systems (ICSs)

For more information on integrated care systems
visit: www.england.nhs.uk/integratedcare/ or www.local.gov.uk/

Sign up to the Integrated Care bulletin: www.england.nhs.uk/email-bulletins/integrated-care-bulletin/

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