The King's Fund

Ideas that change health and care

Developing place-based partnerships

The foundation of effective integrated care systems

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Key messages

- Major changes are taking place in the way health and care is organised in England. Integrated care systems (ICSs) are being established in all areas of the country to drive improvements in population health by integrating services to provide better, more joined-up care for patients and users.
- Most of the heavy lifting involved in integrating care and improving population health will happen more locally in the places where people live, work and access services. Place-based partnerships within ICSs will therefore play a key role in driving forward change.
- Partnerships involving a broad range of agencies and sectors are able to draw on a wider range of levers to influence health outcomes. This means that some of the most promising opportunities to improve population health come from building broad multi-agency partnerships involving local government, voluntary sector organisations and communities themselves, alongside their NHS partners.
- Places vary widely in their scale and nature, reflecting differences in local geographies, populations, organisational contexts and historical relationships. The ability to reflect and respond to local characteristics is critical and a one-size-fits-all model specifying size, boundaries or ways of working is not appropriate for place-based partnerships to function effectively.
- As place-based working develops, there is a risk that variation in local arrangements could create a lack of clarity around accountability and decision-making. This means that, while continuing to support locally led change, national policy-makers will need to set clear minimum expectations for governance and transparency. In turn, ICSs and place-based partnerships will need to clearly and openly communicate about this with their local populations.
- ICSs are set to be established as statutory bodies from April 2022 with significant responsibilities for NHS planning and funding and developing broader partnerships to improve population health. This process will require careful implementation to avoid detracting from or even undermining the efforts of local place-based partnerships.

- As ICSs move on to a more formal footing, they should continue to focus on the priorities of their local places. Some mature systems have successfully nurtured an approach where the ICS is built up from its constituent places. ICSs should now embed this model by prioritising and supporting the development of their local places, ensuring that they are adequately represented in formal ICS structures and strengthening connections between priorities, governance and leaders at system and place levels.
- As clinical commissioning groups (CCGs) merge and (if proposed legislative changes are passed) their functions are subsumed by statutory ICSs, there is a danger that the advantages of place-based planning and resource management could be lost. To avoid this, it will be important to develop arrangements for ICSs to delegate budgets to place level and for national NHS bodies to provide guidance and support to enable this. Over time, local partnerships should use these flexibilities to develop a more joined-up approach to resource management that makes best use of the total collective resources available to support health and wellbeing.
- ICSs and place-based partnerships should prioritise the relational aspects of their development, with a sustained commitment from leaders to develop collaborative ways of working. While formal changes to structures and contractual mechanisms may be used to underpin collaborative working, these should be seen as supporting tools rather than an end in themselves.
- Evidence indicates that the changes discussed here will take time to deliver results. This means that local and national leaders need to make a long-term commitment to the development of place-based partnerships and ICSs, avoiding the past mistakes of moving swiftly to the next reorganisation if desired outcomes are not rapidly achieved. There should be a focus on incremental change, progressively strengthening partnerships and delivering tangible improvements in health and wellbeing.
- The success or otherwise of place-based partnerships will come down to how they are implemented locally. We have set out a series of principles for local health and care leaders to help guide them in their efforts.

Figure 1 Eight principles to guide the development of place-based partnerships

1. Start from purpose, with a shared local vision
2. Build a new relationship with communities
3. Invest in building multi-agency partnerships
4. Build up from what already exists locally
5. Focus on relationships between systems, places and neighbourhoods
6. Nurture joined-up resource management
7. Strengthen the role of providers at place
8. Embed effective place-based leadership

Introduction

Major changes are taking place in the English health and care system, as the emphasis of NHS policy continues to shift towards promoting collaboration rather than competition as the key tool for improving services. As part of this shift, providers are increasingly working together to develop more co-ordinated services, commissioners and providers are collaborating to collectively plan services and manage resources, and in some places NHS organisations and local authorities are joining up elements of their budgets and services to support the integration of health and social care. The ambition behind these changes is to deliver better, more joined-up care to the increasing numbers of people who rely on multiple services, and to improve population health by prioritising prevention and reducing inequalities.

To support these changes, all parts of England are now covered by integrated care systems (ICSs). Under recent legislative proposals for changes to NHS structures, ICSs are set to be put on to a statutory footing, with significant responsibilities for NHS spending and performance.

ICSs typically cover populations of over a million people, but a key premise of ICS policy (and a core feature of many of the systems that have been working as ICSs the longest) is that much of the 'heavy lifting' of integration and improving population health will, in fact, be driven by commissioners and providers collaborating over smaller geographies within ICSs (often referred to as 'places' – *see* box below) and through teams delivering services working together on even smaller footprints (usually referred to as 'neighbourhoods').

The rationale for collaborating over these smaller geographies is two-fold. First, collaboration at this level creates opportunities to bring together budgets, planning and service delivery for non-specialist health and care services (particularly community-based services) to deliver better co-ordinated and personalised care, avoid duplication and improve the efficiency of services. Bringing together budgets and services in this way is also intended to support a wider shift towards

prevention, population health and tackling inequalities as it is at this local level where the many organisations responsible for shaping the determinants of health – whether NHS, local authority, voluntary and community sector (VCS) organisations or others – can come together to understand and respond to local needs.

The second part of the rationale for working together at this level is the opportunity to build a different relationship with communities themselves, framed around local people being active partners in creating healthier places and communities. As later sections of this report will argue, this shift needs to be a fundamental part of place-based working if it is to deliver the improvements in population health and reductions in health inequalities that partnerships seek to achieve.

While working together across the wider geographies covered by ICSs may be helpful for issues that benefit from being tackled at scale, there is a danger that focusing too much on activities and structures at this level risks detracting from or even undermining the local collaboration described above. To make a reality of ambitions to deliver more joined-up care and bring about meaningful improvements in population health, there will need to be a major focus on strengthening partnerships at the level of place.

Defining place

In this report, we use the term 'place' to refer to the geographical level below an ICS at which most of the work to join up budgets, planning and service delivery for routine health and care services (particularly community-based services) will happen.

The factors that determine the size and boundaries of a place will vary. More often than not, place is synonymous with local authority boundaries. Where unitary authorities exist, those boundaries are generally being used to define the place footprint. However, where there are two-tier local authorities, it can be more complex to define the suitable scale and boundaries for place. In some such cases, place footprints have been established around clusters of district councils, the area served by a hospital or established groupings that are already being used for joint working across the NHS and local government.

About this work

This report seeks to understand how partnerships at the level of place (described here as place-based partnerships) are forming and to provide local health and care leaders with a set of principles to support their approach to working at place.

The report aims to:

- explore the potential role and contribution of place-based partnerships by drawing on evidence and insights within the existing literature on place-based working
- understand the approach being taken by some local systems that have prioritised the development of place-based partnerships within their ICSs
- draw out learning for other areas as they work to evolve their approach
- consider the national policy implications of this way of working and what national NHS bodies can do to support its development.

The report seeks to offer greater clarity and guidance, while recognising that this will need to be adapted according to local circumstances and that there should not be a one-size-fits-all approach.

Our research consisted of the following components.

- A review of published literature exploring place-based working in health care and wider public services.
- Scoping conversations with stakeholders (national policy-makers and system leaders) to understand key issues and areas of interest.
- An exploration of the approach to place-based working in three example systems that have developed a clear vision for how their place-based partnerships will operate (Nottingham and Nottinghamshire; Suffolk and North East Essex; West Yorkshire and Harrogate) through in-depth qualitative interviews.
- A small number of focused interviews with local and national leaders selected based on their specific experience and expertise in relation to key themes emerging from the work.

- Two engagement sessions with executive leads and independent chairs from ICSs in England (supported by NHS England and Improvement and the NHS Confederation) to discuss the implications of our findings.
- Three roundtable discussions (in partnership with National Voices and the Local Government Association (LGA)) with participants drawn from local government, VCS organisations and social enterprises, to explore the perspectives of non-NHS partners working at place.

The research was conducted between August and November 2020, meaning it was completed before the publication of the government's recent *Integration and innovation* White Paper and before NHS England and NHS Improvement's paper on *Integrating care: next steps to building strong and effective integrated care systems across England*.

For more detail on our research methodology, *see* Appendix.

These research activities were funded through a commission from NHS England and NHS Improvement. The aim of this commissioned work was for The King's Fund to explore how place-based partnerships were forming and operating within ICSs with a view to informing NHS England and NHS Improvement's policy development over the second half of 2020. This report draws on the evidence and insights gathered for that commission, but the report itself has been produced independently by The King's Fund and draws on our wider body of work on integrated care and place-based working. The views expressed here are those of the authors.

The structure of this report

- Section 1 provides some context for this work by offering a brief overview of the relationship between place and public services, including relevant past initiatives, and outlining recent developments in national policy around ICSs and place.
- Section 2 then draws on insights from existing literature on place-based working, together with insights from our interviews and roundtable discussions, to explore how place-based partnerships can contribute to the improvement of health and wellbeing, setting out a number of core functions.
- Section 3 brings together insights from our interviews, roundtable discussions and the wider literature into a series of principles guiding the approach to building and developing place-based partnerships, exploring how each principle can be applied in practice.
- Finally, Section 4 looks across our findings to consider the implications for national policy.

1 Background

This section sets the context for our work by providing a brief account of previous efforts to improve public services and health and wellbeing through place-based working. It then sets out the latest developments in NHS policy related to this agenda and considers how these are being put into practice.

Public services and place

Place has been a prominent theme in the literature about public service reform – domestically and internationally – for some years. Debates about modernising public services to reflect changing needs have highlighted two key issues relevant to discussions about place. First, addressing social needs through vertical departmental portfolios – for example, health, housing, welfare, education, justice – is poorly suited to people's real needs, which often require co-ordination across services. Second, the centralisation of decision-making authority to national bodies or government departments can make it difficult to respond to varied local needs and reinforces national, rather than local, accountability. The interest in place-based working has also been informed by a growing recognition of the role that places and communities play in shaping people's health and wellbeing (**Buck *et al* 2018**).

There have been a range of initiatives in England over many years designed to enable cross-sector working in place. Such approaches are particularly well-established in local government, through initiatives such as: the Urban Programme (established in 1968); City Challenge and the Single Regeneration Budget (both in the early 1990s); the New Deal for Communities (launched in 1998); the Neighbourhood Renewal Fund and Total Place initiative (launched in 2000 and 2009 respectively); and the devolution of powers to combined authorities and directly elected mayors (from 2016 onwards) (**Taylor and Buckly 2017**). There have also been related initiatives specifically within the health sector, including: health action zones in the late 1990s; spearhead areas in the mid-2000s; the integrated care pioneers in the mid-2010s; the creation of health and wellbeing boards under the 2012 Health and Social Care Act; new care models following the 2014 *NHS five year forward view*; sustainability and transformation partnerships (STPs) established in 2016; and now integrated care systems (ICSs).

The result is a wealth of experience – accumulated over several decades – derived from parts of the country that have tried new ways of working organised through the lens of places and place-based working. There is a wide body of literature exploring the learning for health and care services (*see*, for example, New Local Government Network and Collaborate 2016; NHS Confederation *et al* 2016; Ham and Alderwick 2015).

In our previous work, The King's Fund has made the case for a more integrated approach to health and care services organised around place-based systems of care (Ham and Alderwick 2015; Ham and Curry 2010). To improve population health and tackle inequalities, place-based collaboration also needs to extend beyond the health and care sector, incorporating other agencies, organisations and sectors that have an impact on the health and wellbeing of the population (Buck *et al* 2018; Alderwick *et al* 2015).

How place is reflected in current health care policy

The objectives of ICSs

As of April 2021, all parts of England are covered by ICSs – partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other partners. It is hoped that they will be vehicles for: achieving greater integration of health and care services; improving population health and reducing inequalities; supporting productivity and sustainability of services; and helping the NHS to support social and economic development (NHS England and NHS Improvement 2020).

ICSs are the latest in a long line of policy initiatives to support integrated care (National Audit Office 2017). They have developed from STPs and often build on longstanding local partnerships, including those built through the vanguard programme, which developed and tested integrated delivery models described in the Forward View (NHS England *et al* 2014).

The case for collaborative working in the health and care system has been strengthened by the experience of the Covid-19 pandemic. Hospitals joined forces to offer mutual aid and support to continue the provision of essential services, and NHS, local government and voluntary and community sector (VCS) organisations worked together like never before to enable people to remain well in their homes

and communities and to support vulnerable groups including those who were shielding. Much of the integrated working through the pandemic occurred in local places, driven by organisations and leaders working together across established communities and geographies. While not universally the case, many health and care leaders emerged from the first wave of the pandemic with renewed conviction about the benefits of collaboration and a determination to keep hold of and build on the progress made (Charles *et al* 2021).

Systems, places, neighbourhoods

ICSs are expected to work through smaller geographies within their footprints, building up from local places and neighbourhoods (NHS England and NHS Improvement 2020). A three-tiered model of systems, places and neighbourhoods has been proposed by NHS England and Improvement in their guidance on ICSs (*see* box below). While this three-tiered model is an over-simplification of the diverse set of arrangements and contexts seen in reality, the terminology is now in widespread use within the NHS.

Guidance from NHS England and NHS Improvement on systems, places and neighbourhoods

Neighbourhoods (populations circa 30,000 to 50,000 people*): served by groups of GP practices working with NHS community services, social care and other providers to deliver more co-ordinated and proactive services, including through primary care networks (PCNs).

Places (populations circa 250,000 to 500,000 people*): served by a set of health and care providers in a town or district, connecting PCNs to broader services, including those provided by local councils, community hospitals or voluntary organisations.

Systems (populations circa 1 million to 3 million people*): in which the whole area's health and care partners in different sectors come together to set strategic direction and to develop economies of scale.

* Numbers vary from area to area, and may be larger or smaller than those presented here.

Source: NHS England and NHS Improvement 2019a.

Many advanced ICSs are already working in a way that emphasises the importance of more local levels of organisation. In a report by The King's Fund tracking the first year of ICSs, system leaders suggested that between 70 per cent and 90 per cent of the activity should be at the place and neighbourhood levels, while the system level should account for the remaining 10 per cent to 30 per cent, with activities at this level limited to setting the overall vision, providing system leadership and undertaking functions that are best performed at scale (**Charles *et al* 2018**).

However, there has been a stronger focus nationally on structures at ICS level, including clinical commissioning groups (CCGs) merging onto ICS footprints, the creation of provider collaboratives among NHS trusts working across ICS footprints, and the prospect of legislation to put ICSs onto a clearer statutory footing. In November 2020, NHS England and NHS Improvement published *Integrating care: next steps to building strong and effective integrated care systems across England*, which put forward two potential legislative options for ICSs. Under both options, place-based partnerships were intended to be a key building block of ICSs (*see* box).

Key guidance on 'place' from the NHS England and NHS Improvement document (2020), *Integrating care: next steps to building strong and effective integrated care systems across England*

This document set out a number of expectations for how place-based partnerships should operate. These included the following.

- There must be agreed joint decision-making arrangements with local government at place.
- At a minimum, place-based partnerships should include: local authorities, including directors of public health; Healthwatch; community and mental health services; and primary care leaders (with places being free to add further members as they wish).
- There should be a designated place leader 'on behalf of the NHS' and they must be represented on the ICS board.
- ICS leaders will be expected to use new financial freedoms to delegate 'significant budgets' to place level, which might include resources for general practice, other primary care, community services, and continuing health care.

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Key guidance on 'place' from the NHS England and NHS Improvement document (2020), *Integrating care: next steps to building strong and effective integrated care systems across England* *continued*

The document does not define the exact division of roles and responsibilities between ICSs and their constituent places. It leaves freedom for systems to determine this locally, but indicates that decisions should be based on the principle of subsidiarity, with the system taking responsibility for areas of work only where there is a need to work at greater scale.

Source: NHS England and NHS Improvement 2020.

Following a short engagement process, these proposals were taken a step further with the publication of a government White Paper, *Integration and innovation: working together to improve health and social care for all*, which sets out legislative proposals for a Health and Care Bill (Department of Health and Social Care 2021). At the heart of the changes is a proposal to establish ICSs as statutory bodies in all parts of England. Statutory ICSs will be made up of two parts: an 'ICS NHS body', responsible for NHS strategic planning and allocation decisions and accountable to NHS England for NHS spending and performance; and an 'ICS health and care partnership', bringing together a wider set of system partners to develop a plan to address the broader health, public health and social care needs of the population, and promoting partnership arrangements. It remains to be seen how this dual structure will operate in practice. The ICS NHS body will take on the commissioning functions of CCGs (meaning that CCGs will be subsumed into ICSs) and some of those of NHS England within its boundaries.

The White Paper highlights 'the primacy of place' and sets expectations for place-based partnerships to form a central part of ICSs (*see* box).

Key guidance on 'place', from the White Paper *Integration and innovation: working together to improve health and social care for all*

- A key responsibility for ICSs will be to support place-based working between the NHS, local government, community health services, and other partners such as the voluntary and community sector.
- There will be no legislative provision for arrangements at place level.
- Recognising the variation between places, local systems will be free to develop their own arrangements at place, building on existing partnerships where these are working well.
- NHS England will work with ICS NHS bodies on different models for place-based arrangements.
- ICS NHS bodies will be able to delegate significantly to place, including organising some funding decisions around this level – for example, through joint committees (although this will also be left to local determination).
- There is an expectation that the legislative changes will 'complement and reinvigorate place-based structures for integration between the NHS and Social Care' such as the Better Care Fund and pooled budget arrangements.
- ICSs will be expected to work closely with health and wellbeing boards (which usually operate at place level). ICS NHS bodies and health and care partnerships will have formal duties to have regard to joint strategic needs assessments (JSNAs) and joint health and wellbeing strategies produced by health and wellbeing boards.

Source: Department of Health and Social Care 2021.

Subject to the successful passage of a health and care bill through parliament, it is intended that these proposals will be implemented in 2022.

How this is being implemented in practice

While the model of systems, places and neighbourhoods provides a framework, there are wide variations in how it is being put into practice. This includes variation in the size of systems and places, how the different levels relate to one another, and their relationship to local authority and other organisational boundaries. For some

small and relatively contained systems (such as some of those in the South West), ICSs are operating across population sizes that in other geographies would likely be conceptualised as places rather than systems. In contrast, in some large and complex systems (such as some of those in London), groupings of places are forming to provide a basis for an intermediate level of activity that requires scale greater than an individual place, but smaller than the ICS. The examples below illustrate some of this variation.

Figure 2 Examples of how ICSs are organising themselves into places and neighbourhoods

Greater Manchester

- **ICS** covers a population of 2.8 million. This spans the 10 borough councils, the footprint of the pre-existing GM health and social care partnership, the area covered by the GM devolution deal and the elected mayor.
- **10 places** (described as local care organisations), each of which is coterminous with a metropolitan borough council.
- **58 primary care networks**

North East London

- **ICS** covers a population of 2 million. This spans 8 borough councils.
- **7 places** (described as place-based systems), 6 of which are coterminous with boroughs and 1 of which covers the 2 neighbouring boroughs of City and Hackney.
- Extra tier of multi-borough groupings – 3 'local systems' based on pre-existing footprints of partnership working.
- **48 primary care networks**

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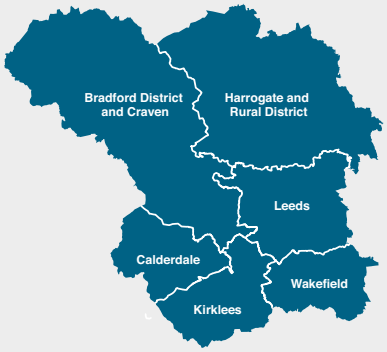
Figure 2 Examples of how ICSs are organising themselves into places and neighbourhoods *continued*

West Yorkshire and Harrogate

- **ICS** covers a population of 2.5 million. It spans 8 local authorities, which are a mixture of unitary and two-tier councils.
- **5 places**, some are coterminous with unitary/ upper-tier council boundaries while some span more than one, based on established local geographies.
- **52 primary care networks**



Suffolk and North East Essex

- **ICS** covers a population of 1 million. This spans 2 upper-tier local authorities – all of Suffolk County Council and part of Essex County Council
- **3 places** (described as locality alliances) follow established organisational footprints, reflecting the pre-merged CCG footprints and flows around acute providers. Each alliance includes more than one lower tier local authority.
- **25 primary care networks**

Nottingham and Nottinghamshire

- **ICS** covers a population of 1 million. This spans 2 local authorities – a unitary city council and the majority of the 2-tier county council (the rest of which sits in a neighbouring ICS).
- **3 places** (described as integrated care partnerships). One is based on the footprint of the city, and is coterminous with the city council, while the other two each cover several of the seven district councils within the county. They roughly align to patient flows into the 2 acute providers.
- **20 primary care networks**

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Figure 2 Examples of how ICSs are organising themselves into places and neighbourhoods *continued*

Dorset

- **ICS** covers a population of around 800,000. This spans 2 recently established local authorities – Dorset Council and the Bournemouth, Christchurch & Poole unitary authority
- **2 places** each of which is coterminous with the unitary local authorities
- **18 primary care networks**

A note on terminology

In many areas, partnerships forming at place level are referred to as integrated care partnerships (ICPs – an acronym that may alternatively be used to refer to integrated care providers). However, there are variations on this terminology – for example, in the Suffolk and North East Essex ICS, such partnerships are referred to as 'alliances'; in South East London, they are described as 'local care partnerships' (LCPs); and in Greater Manchester, they are called 'local care organisations' (LCOs). These different terms reflect local preferences rather than signifying differences in the nature of the partnerships. For the purposes of this report, we use the term 'place-based partnerships' to refer to all these types of arrangements.

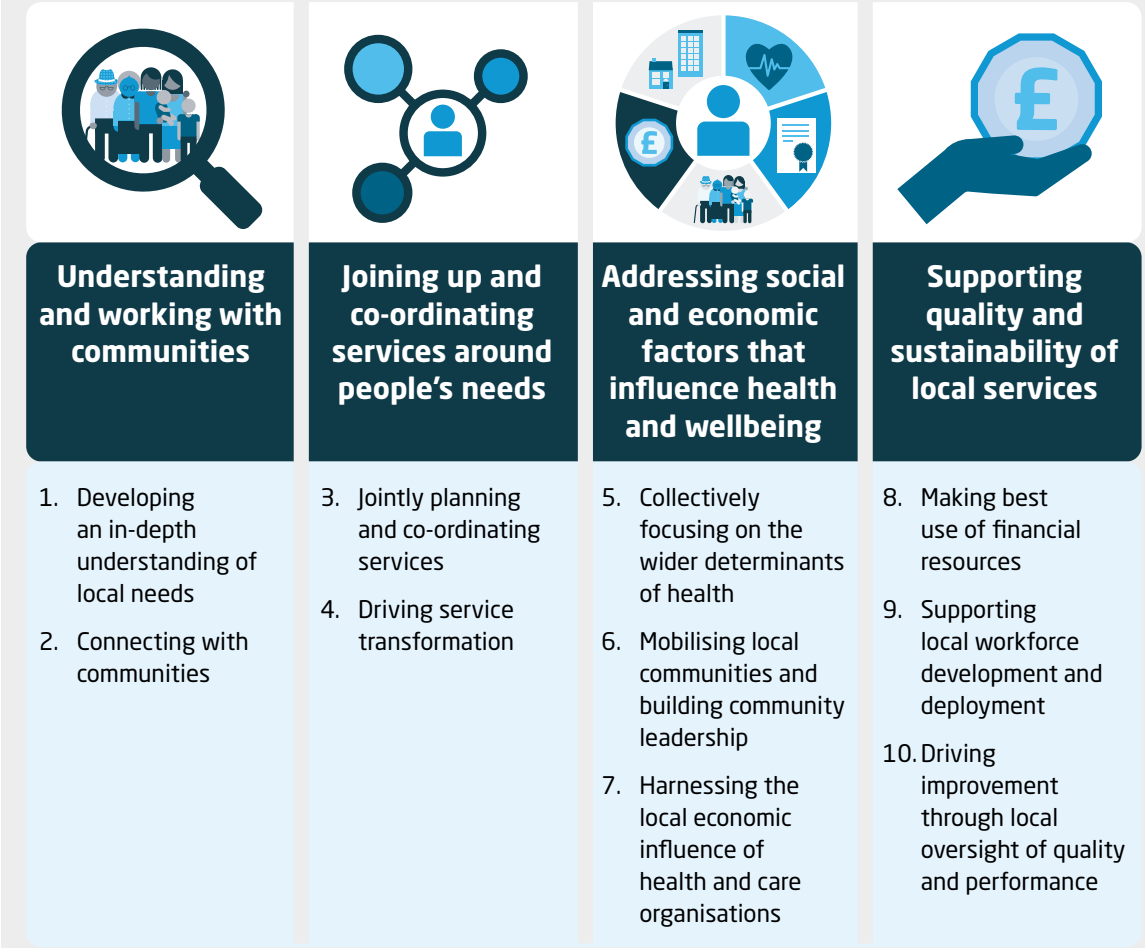
So far, the national NHS bodies have adopted a relatively permissive approach, meaning that – in contrast to many previous attempts at NHS reform – the design and implementation of ICSs has been locally led within a broad national framework. While the latest legislative proposals will lead to greater consistency in governance and responsibilities at system level, they still leave significant flexibility for local areas to determine their own arrangements, particularly at the level of place. This permissive approach has created a level of variation across the country that can make the reforms more difficult to understand. There are some concerns that this could lead to confusion and unclear accountabilities. On the other hand, it can be argued that the variation reflects the reality of the inherent complexity of local health and care provision and has the advantage of enabling systems to build on the strengths of their local leadership and existing relationships. We return to explore some of these tensions and potential trade-offs in Section 4.

2 Key functions of place-based partnerships: understanding where they can add value

Drawing on the existing literature on place-based working, together with insights from our interviews and roundtable discussions, this section explores how place-based partnerships can best contribute to improving health and wellbeing and reducing inequalities, and in particular, where they have the greatest potential to add value over and above the contributions of individual organisations or entire systems. These areas are set out below as 10 functions, grouped under four domains of place-based working. As systems and places establish their purpose and priorities, we would invite them to consider these functions and how they can best be delivered locally.

Given wide differences in the scale and characteristics of systems and places, it is inevitable that there will be some variation in where and how different functions are delivered across the country; something that it makes sense to do at place level in one part of the country might sit better at ICS level in another area, and vice versa. As ICSs and the place-based partnerships within them develop, it will be important to establish how the different levels of collaborative working can contribute to the overarching goal of improving health and wellbeing and reducing inequalities, ensuring that the activities taking place are complementary. To achieve this, the different levels will need to act not as distinct entities, but as a connected and mutually reinforcing set of arrangements with some degree of consistency in their overall strategic direction and ways of working (we explore approaches to this in greater detail in Section 3, principle 5).

Figure 3 Key functions of place-based partnerships



Understanding and working with communities

1. Developing an in-depth understanding of local needs

This involves bringing together data and insights from different agencies to build up a rounded picture of the needs and strengths of different communities at a very local, granular level. Population health management tools may be used to support this. Place-based partnerships can draw on information that already exists – for example, in JSNAs – and build on this by bringing together data and insights from a wider range of sources, including from direct engagement with local communities. These insights can be used to shape priorities for the place and articulate a

collectively agreed ambition for the health of local people and the services they receive. Data can then be used on an ongoing basis to adjust priorities and enable partners to hold one another to account for delivering their ambitions.

2. Connecting with communities

Places should continue to be the geography at which most public engagement in planning decisions relating to health and care happens, as changes in services at a local level are likely to be more meaningful to people than wider system changes. Place-based working also offers opportunities to understand how care pathways are experienced from a user perspective and whether efforts to create better co-ordinated, personalised services are working – new measures of integrated care could offer valuable insights at place level (Wellings 2018). There are also opportunities through place-based working to change the way that community engagement and involvement takes place, establishing a co-ordinated approach to this between partners. Instead of involvement being limited to discrete engagement and consultation exercises, public services across a place can move towards a culture of working with communities on an ongoing basis to understand their priorities and needs, and work with their strengths. Existing community networks and leaders can play an important role in facilitating this.

Joining up and co-ordinating services around people's needs

3. Jointly planning and co-ordinating services

This involves joining up planning and delivery between NHS services across a place, and across NHS, local government, VCS and independent sector services in order to deliver better co-ordinated and personalised care and to avoid duplication and inefficiency. At the level of place, this will particularly focus on joining up community-based services, including primary care, community health services, social care and some community mental health services. Delivery will often be centred around local neighbourhood footprints (this is the level at which community-based multidisciplinary teams are likely to operate, for example). The involvement of local government and other partners creates opportunities to extend the scope of collaboration beyond NHS and social care – for example, to connect with local housing teams, schools, police, employment and welfare services.

4. Driving service transformation

Place-based partnerships can play an important role in driving the development of new care delivery models to respond to the changing needs of a local population, supporting the shift to more person-centred and preventive approaches to care. While transformation of specialist services is best managed on a larger scale (often at the level of an ICS), delivery models for primary and community care need to take local factors into account, meaning place-based partnerships will often be well-placed to lead these changes. This might also include working with acute providers to move the delivery of some higher-volume secondary care services into community settings. Partnerships at place and system levels can help to ensure that these changes occur in a strategic way, taking into account the impact on wider services.

Addressing social and economic factors that influence health and wellbeing

5. Collectively focusing on the wider determinants of health

Health and wellbeing are influenced directly and indirectly by our social and community networks and the physical, social and economic contexts in which we live. Characteristics of local places that will influence the health and wellbeing of those who live and work there include factors such as housing, green space, employment and leisure. The leadership of upper- and lower-tier councils is therefore critical if place-based partnerships are to act on these factors to improve health and wellbeing and reduce inequalities. Asset-based approaches can also be used to identify the strengths within a local area – spanning physical, social, community, and personal assets – harnessing these to improve population health.

6. Mobilising local communities and building community leadership

Place-based partnerships can help to support and strengthen the important contribution of communities to health and wellbeing. This can be strengthened at place through investment in building community leadership capacity – for example, by supporting community-led organisations and creating roles such as community health champions that give local people influence over local health outcomes. Elected councillors and VCS representatives can play an important role in enabling

place-based partnerships to work with community organisations and leaders in this way as they are embedded in local communities in a way that NHS organisations often are not.

7. Harnessing the local economic influence of health and care organisations

There is growing interest in health and care organisations (and other local organisations) acting as 'anchor institutions' within communities by leveraging their role as local employers and purchasers of goods and services to play an active role in protecting the health, wellbeing and economic resilience of their communities. While the system level may have a role in setting the vision for organisations to develop their role in this way, delivering these ambitions will rest on connections and relationships with communities in local places. Place-based partnerships offer an opportunity to support these connections to be built, and to co-ordinate efforts across the key institutions in a place, including NHS providers, local government, academic institutions and other local employers. The stark economic consequences of the Covid-19 pandemic make the role of public sector organisations in supporting local economic recovery and development more important than ever.

Supporting quality and sustainability of local services

8. Making best use of financial resources

This requires partnerships to look at the collective resources available to improve health and wellbeing and, as far as possible, to align these behind the priorities of the place. The complexities of NHS and local government funding mean that true place-based budgets remain more of an aspiration than a reality; however, some areas are taking steps towards this in the way they manage their NHS and local government finances. It is often at the level of place where the greatest opportunities exist to pool functions and funds across the NHS and local government, and many areas are using existing flexibilities such as the Better Care Fund to do so. Some systems have ambitions to go further over time, moving towards a single, capitated budget covering health and care for a local population (*see* Section 3, principle 6). While CCG mergers mean that control of some NHS resources will move further away from local places, NHS England and NHS Improvement has set an expectation that ICS leaders should 'use new freedoms to delegate significant budgets to place' (NHS England and NHS Improvement 2020).

9. Supporting local workforce development and deployment

Much of the activity around longer-term workforce planning, recruitment and training will need to sit at ICS level to bring sufficient scale (this is reflected in NHS England and NHS Improvement's expectations that ICSs will have an increasingly important role in these areas). But there are also opportunities to look at how the collective workforce for health and care across a local place is deployed and developed in support of desired service changes. Workforce development is therefore an area where the division of efforts across places and systems will need careful working through with tailored local solutions. Opportunities at place may include flexible deployment of staff across organisations and integration of teams and training to support multi-agency working. There may also be opportunities through place-based working to help frontline staff to understand and connect with local communities, generating new ways of working that recognise and support the role people and communities can play in improving their own health.

10. Driving improvement through local oversight of quality and performance

Regulation of quality and performance of NHS services is expected to increasingly involve national regulators working closely with ICSs to identify and address system-wide issues, rather than simply working on an organisation-by-organisation basis. This should not be duplicated by creating additional layers of assurance at place, but there may be a distinct role for place-based partnerships in creating informal local accountability mechanisms that can help drive improvement in local services. Peer support and challenge between leaders of different organisations can form an important part of this, drawing on established approaches to sector-led improvement in local government and clinical peer review. Through their governance and ways of working, place-based partnerships can help to foster mutual accountability between partners within a place and outwards accountability to communities, including through local democratic structures such as health and wellbeing boards and overview and scrutiny committees (in addition to the necessary national accountability via NHS structures).

3 Principles to guide the development of place-based partnerships

The following sections set out eight principles to guide the approach to building and developing place-based partnerships (*see* box). These bring together insights from our interviews, roundtable discussions and the wider literature, as well as The King's Fund's longer-term policy and development work on integrated care. We explore how each principle can be applied and include examples of how they are being put into practice.

Figure 1 Eight principles to guide the development of place-based partnerships

1. Start from purpose, with a shared local vision
2. Build a new relationship with communities
3. Invest in building multi-agency partnerships
4. Build up from what already exists locally
5. Focus on relationships between systems, places and neighbourhoods
6. Nurture joined-up resource management
7. Strengthen the role of providers at place
8. Embed effective place-based leadership

Principle one: Start from purpose, with a shared local vision

Key points

- Place-based partnerships should centre their work around a clear, shared vision of what the partnership is trying to achieve for local people and communities. The development of new structures and governance arrangements is secondary to this and must not become the principal focus.
- Setting a local vision starts with an understanding of the population and the place, underpinned by local data and insights.
- Developing a shared sense of purpose requires a process of collaborative development across a wide range of partners, including with local communities.
- Place-based working stands the best chance of success when place footprints make sense to local people and partner organisations across health, local government and the voluntary sector.

A consistent message from the local systems we engaged with as part of this work was that place-based partnerships should be centred around a clear, shared understanding of purpose and what the partnership is trying to achieve for local people and communities. While governance models and leadership arrangements can be important in supporting partnerships to function effectively, we heard that form should follow function, with the focus here being on establishing arrangements to underpin and enable the objectives of the partnership rather than the 'system wiring' being seen as an end in its own right.

The functions outlined in Section 2 provide a framework for where place-based partnerships can most effectively focus their efforts, but the specific priorities within each function and how they are executed will be highly dependent on local factors, including population needs and assets, local system challenges and the resources available. Building a detailed picture of these factors through data and local insights is an important first step in establishing purpose and priorities. Importantly, if place-based partnerships hope to tackle inequalities as a key priority, then they will need to pay particular attention to understanding and involving groups of the population most at risk of poor outcomes. Data and insights will need to be regularly revisited to guide the evolution of priorities over time.

The process of developing the vision can be as important as the vision itself, as it can help to build relationships and establish commitment and buy-in from key stakeholders. Sites involved in our research emphasised the importance of co-creating the objectives and priorities for the place with a broad range of local partners and stakeholders in order to create a sense of common purpose that binds the partnership together. Investing time and effort in this early on can help to set the tone for operating as genuine, multi-agency partnerships across NHS, local authority, VCS organisations and wider partners. In establishing their purpose and priorities, there is also an opportunity for partnerships to lay the ground for a different relationship with their local communities by working alongside them to understand local needs and strengths and consider how to best respond to these (explored further in principle three).

By starting from the benefits that their work will bring local people, it should also be possible for place-based partnerships to articulate a compelling and accessible narrative explaining what the partnership is for and how it will deliver benefits over and above those that could be achieved by its constituent organisations.

National and system priorities will, of course, have a significant role in influencing priorities at place, and national clinical standards will apply. A key role for place-based partnerships is to tailor national and system priorities to their context and to strike an appropriate balance between focusing on national and local priorities in their work. This could create challenges if competing priorities come into tension, particularly as ICSs move on to a statutory basis and the expectations on systems to deliver national commitments increase. In this context, it is all the more important for places to retain a focus on local priorities to bring balance to the agenda of ICSs and ensure that the focus of systems is grounded in the priorities of local communities.

Define footprints based on meaningful geographies and/or communities

Defining meaningful geographical footprints for places is integral to the process of building shared purpose. Stakeholders we spoke to for this project argued that the primary consideration in defining place footprints should be that they make sense to local communities and the partner organisations involved. As described in the introduction to this report, upper-tier or unitary local authority boundaries often form the most appropriate footprint for place, as these often correspond to

natural or longstanding geographies and communities, and form a strong basis for joint working across NHS organisations and local authorities (which control many of the key services that affect health and wellbeing in a place). Where, for whatever reason, an existing local authority footprint is not felt to offer a strong basis for local partnership working across the NHS, local government and wider partners, other factors may be used to determine a suitable footprint. This might be based around clusters of district councils that align to towns or natural communities, around the area served by a local hospital, or around established groupings that are already being used for joint working across the NHS and local government. The LGA has suggested that place boundaries should be determined following local discussion, taking into consideration the role of all partners who contribute to health and wellbeing in an area (**Local Government Association *et al* 2018**).

Taking local factors into account means that places will inevitably vary markedly in size and population. Among the systems we explored for this work, place populations ranged from around 220,000 in Calderdale to approximately 850,000 in Leeds (and other parts of the country likely have greater variances). Similarly, places in urban centres, such as London boroughs, may only be a few square miles in size, while those in more rural areas may cover large geographical territories. This heterogeneity may present challenges for national policy-makers. Places of diverse scales will enjoy different capabilities, face different configurations of services, contrasting challenges, and may relate differently to ICSs. However, there is a strong case to be made that the benefits of working in geographies that are meaningful to local people, staff and public service leaders outweigh the costs of heterogeneity. Avoiding a prescriptive approach to defining place boundaries will give place-based partnerships the best chance of success.

It is also worth noting that establishing place-based partnerships around defined geographical footprints does not mean that all joint working locally must centre around that footprint; different configurations of partners may need to coalesce around specific pathways or objectives. This might involve a subset of partners from a place-based partnership, or two or more places coming together to collaborate around a particular pathway or issue.

Principle two: Build a new relationship with communities

Key points

- Working more closely with local communities creates opportunities for health and care organisations to improve the services they provide and increase their impact on population health and wellbeing.
- Efforts to connect with, support and mobilise communities are likely to have greater impact if pursued by multiple organisations in tandem, and place-based partnerships can play an important role in this by agreeing a shared approach and co-ordinating action.
- Partnerships need to know whether place-based working is leading to improvements for local people and they will not be able to do this without hearing directly from people using services and other community members.

As suggested in Section 2, our work indicates that the key functions of place-based partnerships need to include connecting with communities and supporting local groups to mobilise people to help improve health and wellbeing. Place-based working can help support a shift in the relationship between public services and the communities they serve towards one in which people are treated as active partners in, rather than passive recipients of, care. There are a number of components to this, as follows.

- Jointly establishing a shared vision for the relationship between services and local people and communities.
- Providing common training opportunities to enable health and care professionals to work more closely with local people and communities, and vice versa.
- Gathering user and community insights to understand the impact that place-based working is having, using these insights to drive improvement, and creating feedback loops so that people can see how their input has led to change.

- Promoting ways of working that help partner organisations to be responsive to the insights gained from working more closely with local people and communities.
- Strengthening community resilience by creating leadership roles that local people can play in their communities in relation to health and wellbeing.

Work conducted in a number of places shows what an ambitious approach to community engagement and mobilisation could look like. For example, work in Wigan over several years incorporates many of the components listed above. Partner organisations have coalesced around an approach referred to as the Wigan Deal. This emphasises 'working with' rather than 'doing to' local people, drawing on the strengths and assets of individuals and communities to improve outcomes. Our research on the Wigan Deal found that adopting this approach has involved: articulating a clear vision and holding people to it over time; providing all staff across the local authority and partner organisations with common training in having 'different conversations' with service users; and supporting local people to step into community leadership roles such as health champions, dementia friends, autism friends and other roles (Naylor and Wellings 2019).

Others have argued that examples such as the Wigan Deal provide illustrations of what a fundamentally different relationship between citizens and the state could look like, based on closer collaboration and sharing power and resources with communities (Lent and Studdert 2021). Place-based partnerships could play a critical role in driving this kind of innovation forward because of their ability to help partners move as one. Attempts to build a different relationship with communities are likely to have the greatest impact when they are based on a shared way of working across all of the services operating in a place, rather than being something that one organisation pursues in isolation (Naylor and Wellings 2019).

The value of user and community insights at place level

Place-based partnerships need to understand the impact that place-based working is having in practice. User and community perspectives should be a vital part of this because of their power to shed light on the extent to which people are receiving joined-up, integrated support from the various services they are in contact with. Place-based partnerships can support system-wide learning by bringing a range of public services together around a specific issue, population group or pathway, to understand how the system as a whole can be improved.

Ongoing research by The King's Fund is exploring ways of measuring and understanding the impact of integration from a user perspective (Wellings 2019), highlighting that this work is often most meaningful to communities and staff when it is led at the level of place. First, people can engage meaningfully in a conversation about services in their local place in a way that is not always easy across wider geographies. Second, engagement activities at ICS level may not always be representative of the local population at place level. Third, for them to be of value, user and community insights need to be listened to and acted on, and there is a risk that feedback gathered at ICS level is perceived as less relevant to local services. One of the most promising opportunities for improvement is to enable staff from multiple services to work together to decide what actions they should take, individually and collectively, in response to feedback, and this will often be most feasible at place level.

This is not to say that insights and engagement are *only* needed at place level; they should play an important role at all levels, including in ICSs. Some of the systems involved in our research were beginning to grapple with these issues. For example, West Yorkshire and Harrogate ICS has been exploring what engagement activities should take place at different levels. This will depend on the issue in question; engaging people in the redesign of acute stroke pathways might best be done at ICS level, whereas engagement focusing on the interface between GPs and hospital care would sit better at place level. System leaders are applying the principle of subsidiarity to this as with other aspects of their work.

Involving users and community members in the governance of place-based partnerships

Involving people using services and other community members in the governance of collaborative decision-making structures provides an important way of strengthening local accountability, both at the level of ICSs and within place-based partnerships. Partnership boards should include user and community representatives, and partnerships should also explore other mechanisms to bolster user and community voice within governance arrangements. For example, in West Yorkshire and Harrogate, there is a Patient and Public Involvement Assurance Group whose role is to provide formal assurance that public and patient voice is being adequately represented and heard, and that public and patient views and experiences are informing decisions on the planning, design, implementation and evaluation of services.

Principle three: Invest in building multi-agency partnerships

Key points

- The key to building and sustaining multi-agency partnerships is to ensure that these function as equal partnerships. Local government and voluntary sector organisations need to be able to drive the agenda at place level alongside their NHS partners.
- Without broad involvement, partnerships will be less well-placed to tackle health inequalities or to improve the quality of local services.
- It is crucial to ensure that putting ICSs on a statutory footing does not make it harder to create joint ownership of partnership working at place and system levels.

Participants in our research suggested that some of the most significant opportunities to improve population health and deliver better services come from building multi-agency partnerships that encompass a wide range of organisations and stakeholders, including local government, the voluntary sector, local people and others. Partnerships involving a broad range of agencies and sectors have access to a much wider set of levers that can be used to influence health outcomes.

Key partners include:

- local government (including but not limited to public health and social care)
- voluntary and community sector organisations of various kinds (*see* below)
- people using services and other community members (*see* principle two)
- NHS planners/funders
- primary care (eg, PCNs, GP federations)
- secondary care providers (acute hospitals, mental health and community services).

Beyond this list, there is a broader set of partners that can also play an important role, including other local authority functions (*see* below), local business organisations

and independent sector providers of health and social care services – although practically it may make sense to start with a core group of committed partners and to grow the partnership over time.

To gain the full benefits of multi-agency partnership working there needs to be an explicit focus on strengthening relationships across the partnership. This often starts with closer working between senior leaders directly involved in partnership boards, but there also need to be mechanisms to embed this way of working at other levels, including enabling closer working between frontline staff, and building the different relationship with people and communities described in principle two.

Local authorities

Local authorities are responsible for a wide range of functions that can contribute towards improving health outcomes, including public health, adult social care, early years services, children's services, housing, planning and environmental services. They also have critical roles in stimulating a strong local economy – one of the single greatest determinants of population health – and in providing overall stewardship of a place. In addition to expertise in specific sectors, local authorities often have broader skills and strengths to contribute to partnership working, including their ability to act as a convenor of a very wide range of partners and sectors, and links into communities via elected members and other routes.

Given these wide-ranging responsibilities and skills, it is essential that local authorities are at the heart of place-based working to improve health and care, driving the joint local agenda alongside NHS and other partners. It is also important that involvement spans a range of roles in local government, including directors of adult social services, directors of public health, local authority chief executives, elected members and others.

What this looks like in practice will necessarily vary across the country because of the variation in how local government is structured. As described in principle one, where there are unitary authorities, place-based health and care partnerships are likely to cover the same geography as the local authority, creating a one-to-one relationship. In contrast, in areas with two-tier local government, the alignment can be more complex. The split of functions across the two tiers means that place-based partnerships will often need to engage at both levels – for example,

working with public health and social care teams in county councils and housing teams in district councils. The sites involved in our research where this applies have developed place-based partnerships covering multiple district councils to create sufficient scale. For example, in Mid-Nottinghamshire (one of the three places comprising Nottingham and Nottinghamshire ICS), the four district councils play a key role in the partnership as well as Nottinghamshire County Council.

In places where this complexity exists, it will be all the more important for local NHS leaders to work hard to ensure that their local authority counterparts have genuine ownership and control over the direction the partnership takes. The implication for national NHS leaders is that local leaders must be given the flexibility to construct place-based partnerships in a way that makes sense in the local context; a one-size-fits-all approach will clearly not work (*see* principle four).

Voluntary and community sector organisations

VCS organisations also have a critical role to play in place-based partnerships. Ambitions around reducing health inequalities are unlikely to be met without the close links into communities that VCS organisations can bring. In many places, the ability of VCS organisations to quickly mobilise local people and provide nuanced local intelligence has been indispensable during the Covid-19 pandemic. A thriving local voluntary sector will also be key to making the most of the opportunities presented by the national policy focus on social prescribing.

Involving VCS organisations in place-based working takes thought to get right because of the diversity of the sector, the huge number of organisations involved, and the limited capacity of many smaller grassroots organisations. Some VCS organisations function as service providers, some act primarily as vehicles for expressing community voice, and there are also infrastructure bodies that serve the purpose of supporting the voluntary sector locally. Place-based partnerships should seek to involve a mixture of these very different types of organisations rather than a single representative for the sector.

VCS organisations involved in our research stressed that the resource consumed by participating in collaborative forums can be a significant issue. To sustain voluntary sector involvement over time, it may therefore be necessary to take steps

to actively support this – for example, by providing appropriate remuneration for people's time. Place-based partnerships involved in our research had developed a number of ways to support voluntary sector involvement, including:

- identifying funding for a dedicated post or function focused on enabling VCS involvement (eg, in Leeds, Forum Central is funded to support other local VCS organisations to connect and work with the local care partnership)
- working with representative bodies established by local VCS organisations (eg, a VCS forum/infrastructure organisation)
- having an independent chair from the voluntary sector (for example, as in North East Essex, one of the three places comprising the Suffolk and North East Essex ICS).

As with local authorities, there also needs to be some form of VCS representation at ICS level. However, for many VCS organisations, involvement in place-based partnerships is likely to feel more relevant to their priorities and the communities they work with (a briefing paper from the NHS Confederation suggests a number of ways in which involvement at ICS level can be supported) (**NHS Confederation 2020**).

Creating an equal partnership

A clear message from our research was that multi-agency partnerships need to function as equal partnerships to be successful. This equality should be reflected in a number of ways: the partnership agenda needs to be relevant to all involved; the leadership arrangements need to draw on the wider pool of skills and talents available; the culture and ways of working need to be hybrid; and the measurement indicators need to be meaningful across all stakeholders.

The LGA has argued that it takes ongoing, deliberate effort to build a collaborative culture within place-based partnerships, with the first step being 'for people to understand their partners' priorities, pressures and ways of working' (**Local Government Association *et al* 2018**). Sites involved in our research stressed the time it takes to establish common ground and fully appreciate each other's priorities, challenges, cultures and 'languages'.

The focus of local NHS leaders involved in place-based partnerships should be on contributing to, supporting and strengthening multi-agency working, while avoiding the perception of an 'NHS takeover'. To magnify their impact on population health, NHS organisations need to engage constructively in wider local initiatives and may need to practise the principle of 'giving away power to gain influence'.

Building a genuinely equal partnership requires commitment from all sides. Some of the partnerships involved in our research identified measures that were seen to have helped, as the following examples illustrate.

- In Mid-Nottinghamshire Integrated Care Partnership (ICP), every item that comes to the ICP board has to be co-sponsored by partners from NHS and local government. The ICP has also been working with people with relevant lived experience to help the partnership take a holistic perspective in its work.
- In North East Essex, having an independent chair from the voluntary sector was seen as a helpful mechanism to avoid any single organisation being perceived as having control over the partnership.
- In West Yorkshire and Harrogate ICS, a memorandum of understanding has been agreed, making it clear that the partnership board should function as an equal partnership.

We heard mixed views about the extent to which this principle of equal partnership has been successfully established to date. Some saw place-based partnerships as being more jointly owned than partnership work at ICS level, and there is a risk that planned legislative changes could reinforce this. For ICSs, becoming statutory bodies with legal responsibility for NHS finances and performance risks making it harder to function as a truly equal partnership. In comparison, non-statutory partnerships at place level may find it easier to do so. This could create friction in future at the interface between place-based partnerships and ICSs, and makes this a crucial relationship to get right (*see* principle five). This underlines the value of having strong representation of places within ICSs to ensure that the agenda at ICS level reflects the breadth of concerns of local multi-agency partnerships.

An example of multi-agency working: tackling multiple disadvantage in Nottingham

The city of Nottingham has an estimated 5,000 residents living with 'severe multiple disadvantage' – people living with more than one of a range of needs such as homelessness, substance use, a long-term physical or mental health condition, social isolation or criminal offending.

Recognising that this was a significant local issue requiring a more joined-up response from services, local partner organisations worked together to develop a programme of work focused on people with these needs, with support from the Big Lottery Fund. The approach brings together professionals from a range of public services – mental health, housing, criminal justice, working-age welfare and social services – to offer people living with severe multiple disadvantage a tailored service that is psychologically informed, co-ordinated and aims to promote long-term independence.

Central to the potential of the programme is a focus on sharing local intelligence – both to identify people who may benefit from the service, and to enable a co-ordinated package of support for those who have been identified and to reduce service users having to repeat their stories to different services.

Sources: Nottingham City Council 2019; Opportunity Nottingham n.d.

Principle four: Build up from what already exists locally

Key points

- Wherever possible, partnerships should build on pre-existing agendas, relationships and structures, and embed them into a coherent place-based way of working.
- Health and wellbeing boards are important local partners in place – and can also play a role in ICSs.
- Differences in local government and NHS organisational configurations mean there will not be a universally applicable model for how health and wellbeing boards engage in a place agenda, but it is important that their roles are clarified locally.

Build on and adapt existing collaborative arrangements in place

Place-based working stands the best chance of making an impact if it builds on and adapts pre-existing arrangements. Local leaders we spoke to for this work highlighted a number of examples of how they have worked with colleagues to incorporate and adapt local initiatives or structures so that they feed into a place agenda. This can take different forms, including adapting leadership forums, deepening mechanisms for resource-sharing and rethinking governance arrangements, as the following examples show.

In Leeds, several years ago senior health and care leaders created an informal space for them to co-ordinate and address operational challenges. Over time this forum, the Partnership Executive Group, has been re-purposed to become the key executive leadership space for the place-based programme of work in the city. Its membership has been extended to reflect the changing composition of the partnership.

In North East Essex, they have opted to re-purpose the CCG to support their Alliance. Gradually they have adapted the CCG's governance model – for example, introducing a dedicated sub-committee of the CCG board focused on Alliance business to enable the Alliance's intentions to be actioned in a way that accords with legal requirements.

Alongside adapting existing local structures, partnerships have sought to build on previous programmes of work focused on service integration and cross-sector working (such as the vanguard and integration pioneer programmes and STP plans), and on existing partnerships with VCS organisations (such as those established through social prescribing programmes).

None of this is to say that no new initiatives, collaborative forums or governance models can be introduced at place. In some cases, they will be needed. Indeed, some stakeholders were enthusiastic about the potential value of embedding collaborative ways of working into governance models as place partnerships mature. But the overriding message was to err on the side of adaptation and evolution, building on those instruments already available, and constructing new forums or governance mechanisms selectively where there is a compelling case to do so.

There may be particular challenges for systems where collaborative arrangements have built up around CCGs that are now being required to merge. To avoid progress being undone, it will be important that as commissioning structures change, functions and expertise that can support place-based planning and resource management are retained at this level (*see* principle six).

Health and wellbeing boards – the interface with place

Introduced by the 2012 Health and Social Care Act, health and wellbeing boards (HWBs) are statutory forums bringing together health and care leaders, including elected members, to drive service integration and promote health and wellbeing. They are hosted by local authorities with responsibility for adult social care and public health (upper tier or unitary), and are responsible, alongside CCGs, for producing a JSNA and health and wellbeing strategy for the local population (for more detail *see* **The King's Fund 2016**).

Experience has shown that HWBs around the country vary in their approach and effectiveness (**Local Government Association 2019**); there has also been a perception, in some quarters, that the development of ICSs has clouded the role of HWBs (**Humphries 2019**). Yet HWBs have a number of important attributes from the perspective of place-based working: they are focused on defined geographies; they bring together health and local government stakeholders; the involvement of

elected members brings a different dimension of local accountability (and, arguably, legitimacy); and their position as formal committees of a council can enable public involvement.

Stakeholders we spoke to for this work saw their local HWB as an important partner in shaping their local agenda and driving that forward, and had, in most cases, made a strategic decision to engage the HWB so as to enable the place agenda to reflect local needs and resonate across health and local government. The common goal was to design and embed a dynamic of interaction between the HWB and place-based partnership that demarcated responsibilities and added value to the programme of work.

Progress towards this goal varied among the places we explored. Some stakeholders reflected that their place-based partnership and local HWB were on a development journey to reach a modus operandi that was mutually beneficial. Interviewees highlighted two key reasons for this variation:

- *Geography:* For those places where the HWB and place are coterminous, it was generally felt that the respective roles and responsibilities were simpler to agree and articulate. Conversely, where a HWB's geographical remit spans multiple places and where it is working in a two-tier local government geography, the relationship needs to be conceptualised differently.
- *Variation in the approach of the HWB:* The 2012 Act conferred responsibilities on HWBs but left much of the detail of how they operationalised their role to be established locally. Consequently, HWBs have been able to define their own role in their local health and care system.

Unsurprisingly, given this variation, the places we examined for this work articulated different formulations for how their place-based partnership dovetails with their local HWB and vice versa. The common theme was that they all sought to develop a model of interaction that made sense in their local organisational configurations. Two examples illustrate the differences in approach.

- The Essex County Council HWB, which operates within a two-tier geography and spans a footprint encompassing five places in three STPs/ICSs, conceptualises its health and wellbeing strategy as a framework that places can tailor to local population needs. The health and wellbeing strategy seeks

to identify some priority areas that inform local priorities rather than being too granular or prescriptive. Alongside this, the HWB seeks to support its places through devoting agenda space to sharing ideas and learning between places in Essex.

- In Nottingham City, which has a unitary council that is coterminous with the Nottingham City ICP footprint, the HWB and ICP articulate their relationship differently. Broadly, the HWB sees itself as setting the strategy for the Nottingham City place through its health and wellbeing strategy and conceptualises the ICP as leading on implementation of that strategy. The HWB maintains an oversight and assurance function whereby it provides constructive challenge to the ICP and incorporates perspectives from outside health and care, including (for example) housing, welfare and emergency services. There is some overlap between the organisations and individuals participating in the two forums.

In the systems we looked at as part of this work, HWBs were also complementing their role by helping to develop alignment between system agendas and place work. Often this meant that the chair of the HWB had a seat on the ICS partnership board or equivalent forum. In other parts of the country, some HWBs are adapting to be able to contribute more effectively – for example, by forming joint arrangements (across multiple places) to feed into system deliberations or by changing their membership to reflect the broad multi-agency ethos of system working (for instance, by incorporating provider representation).

Recent legislative proposals for ICSs seek to embed this relationship by highlighting the importance of 'bringing together ICSs and HWBs as complimentary [sic] bodies at system and place level' and requiring ICS NHS bodies and ICS health and care partnerships to have regard to the JSNAs and joint health and wellbeing strategies produced at HWB level, and vice versa (**Department of Health and Social Care 2021**, p 55).

Looking to the future, interviewees saw opportunities to further refine the pattern of interaction between place-based partnerships and HWBs. They acknowledged that the dynamic will need to evolve as partnerships mature. In some cases, they saw a role for organisational development to support the place partners and the HWB to collectively iterate their ways of working.

Principle five: Focus on relationships between systems, places and neighbourhoods

Key points

- Place-based partnerships need to establish how they relate to surrounding places and to partnerships at other geographical levels (including ICSs and local neighbourhoods) to ensure that their activities are complementary.
- The exact division of responsibilities will need to be determined locally given the significant variation in the scale of places and systems and the inevitable interdependencies between them.
- Central to these decisions should be the idea of subsidiarity: that decisions should be made as close as possible to local communities, and that activities should only be led at scale where there is good reason to do so.
- ICSs are made up of their constituent places. They should operate as a mechanism for working across places to bring benefits of scale rather than as distinct entities in a hierarchy.

Place-based partnerships do not stand alone; they are part of a complex network of organisations and partnerships operating across a geographical area. It has previously been argued that the development of integrated health and care will require 'systems within systems' to focus on different objectives (Ham and Alderwick 2015) as the level of partnership that is best placed to lead a response will depend on the nature and scale of the issue in question. This approach is now being put into practice through the emerging model of systems, places and neighbourhoods.

As place-based partnerships form, they will therefore need to establish how they relate to their surrounding places and to partnerships at other geographical levels (including the ICS and local neighbourhoods) in terms of functions, decision-making and their underpinning governance. This is essential to ensure that they form part of a coherent, mutually reinforcing approach rather than creating a disjointed set of initiatives with unclear roles and accountabilities.

Our work has highlighted that there is no simple answer to the question of what activities should sit where. Part of establishing the relationship between

different levels within a system is to recognise that there will be overlaps and interdependencies between them.

The appropriate division of activities will also differ depending on the scale of the system or place in question. Given the wide variation in the scale and characteristics of local systems and places noted previously, the division of responsibilities will need to be determined locally. In addition, the capacity and capabilities across systems, places and neighbourhoods will change over time as partnerships mature, so the balance of responsibilities and autonomy will be subject to ongoing revision and adaptation as this evolves.

Applying the principle of subsidiarity

A guiding principle to shape these local decisions is the principle of subsidiarity – the idea that decisions should be made as close as possible to local communities, and that activities should only be led at scale where there is good reason to do so or they cannot be carried out at a more local level.

Different systems are taking different approaches to applying this principle in practice.

- Some have agreed a set of guiding principles – for example, in West Yorkshire and Harrogate ICS, partners have agreed that they will always work locally (through the constituent places), unless the issue passes one or more of three tests:
    1. It is necessary to work on a bigger geography to achieve a critical mass to get the best outcomes (eg, for specialist services such as stroke or cancer care).
    2. There is unacceptably high variation in outcomes and working together will improve quality, reduce variation and provide opportunities to share best practice.
    3. There is opportunity to work together to tackle 'wicked issues' by attracting resources, energy or new thinking.
- Some systems have undertaken mapping exercises to categorise functions and activities and to determine what level of their local system each should sit at.

- Others are approaching this on a case-by-case basis through agreement between partners, supported by a shared understanding of the overall vision for the system and places.

In practice, it will not always be straightforward to apply these principles, and there is potential for tensions and disagreements to arise. As arrangements evolve, it will be important to balance appropriate scope for local determination against the need for transparency and clear accountability for where key decisions sit. The following sub-sections explore how relationships between systems and places, and between places and neighbourhoods, are evolving so far.

The relationship between system and place

In the systems we looked at as part of this work, there was a strong emphasis on avoiding seeing ICSs and places as separate bodies in a hierarchy. Instead, we heard that an ICS is made up of its constituent places and should be understood as a mechanism for working across them. This means that places need to be represented through the ICS governance structure.

So far, some systems have tried to minimise the infrastructure at ICS level to avoid it feeling like a separate body, drawing instead on the contribution of leaders from the constituent places and organisations. In practice, organisations and individuals are simultaneously playing roles at both place and system levels, but the focus and weight of their contributions may look different at each level. While this can bring benefits, it also needs to be balanced against the demands on leaders' time and the need to ensure adequate capacity and capability to support the work of the ICS.

While emphasising the importance of place, the interviewees included in this work were clear that a number of important roles are best undertaken across the entire ICS to bring benefits of scale. Key roles for the ICS include:

- convening partners to set the overall vision and standards for the system, and supporting and holding partners to account for delivering them (places can work within this strategic framework, adapting it according to local population need)

- planning specialist services across larger footprints, such as stroke, trauma and cancer services
- leading on the strategic development of key enablers such as digital, estates and workforce planning
- managing upward accountabilities in the NHS, including holding the relationship with regional and national NHS bodies
- agreeing and articulating expectations for how system partners work together and setting shared values
- giving areas of strategic importance more impetus – for example, by setting system-wide expectations around diversity and inclusion.

We also heard that ICSs have an important role in enabling and supporting the places within them. This means ensuring that there is appropriate resource, autonomy and capability at a local level. It also requires ICSs to ensure that the work programmes of their local places do not become disconnected from each other. This could involve setting an overall strategic direction, supporting place-based partnerships to ensure that the decisions they take have sufficient regard to surrounding places and the wider system, and supporting the sharing of best practice across geographies.

In line with the principle of subsidiarity, leaders in some systems emphasised 'the primacy of place' and the value of viewing the system as 'the servant of place'. However, we also heard concerns that central NHS asks are increasingly pulling ICSs towards a narrower focus on NHS performance and meeting regulatory requirements, drawing ICSs' priorities away from those of their local places. This could become increasingly challenging as ICSs are established as statutory NHS bodies with increased responsibility and accountability for NHS finances and performance. Depending on the outcome of the legislative proposals, there is a risk that fault lines could appear with a new, more hierarchical, dynamic emerging between statutory ICSs and non-statutory place-based partnerships.

The relationship between neighbourhood and place

Much of the delivery of integrated care will happen through multidisciplinary community teams organised around local neighbourhoods. This means that place-based partnerships will not be able to achieve their objectives without strong connections to their local neighbourhoods and the PCNs operating across these footprints. PCN clinical directors and/or neighbourhood team leaders can play an important role within place-based partnerships by offering clinical leadership, ensuring that the voice of primary care provision is heard in key decisions, and bringing granular local insights to help drive the agenda.

The involvement of primary care is also important at the level of the ICS, but this requires some co-ordination (it will not be practical for all PCN clinical directors to be represented on an ICS partnership board given the large number of PCNs in most systems). In some systems, this is being addressed by PCNs coming together across a place and nominating one or more representatives to represent them at the ICS. We heard from interviewees that while the system level can feel distant or even irrelevant to those leading PCNs or neighbourhood teams, the level of place often feels more meaningful, and they can more readily identify with the purpose and activities of these partnerships. As a consequence, place-based arrangements can act as an important bridge between ICSs and neighbourhoods.

Place-based partnerships and/or ICSs can also offer support to accelerate the development of PCNs and neighbourhood working (indeed, NHS England and NHS Improvement recently highlighted this as one of the four main roles of place-based leadership) (**NHS England and NHS Improvement 2020**). This may include operational support to general practice, which is highly variable and often lacking. It may also include strategic support to develop new ways of working; at present, many PCNs are focusing internally on managing day-to-day pressures and building trust and relationships within nascent networks, leaving little time to engage beyond general practice. Moving to broader neighbourhood working will require change across a range of providers spanning general practice, community, mental health and acute trusts, as well as social care and VCS providers, which is unlikely to be achieved by PCNs working in isolation.

In providing any such support, it is important to design this in partnership with local PCNs and neighbourhood teams so that it responds to their needs. It also needs to reflect the existing infrastructure available to support primary care, which is highly variable. In some areas, federations, large practices, community trusts or vertically integrated providers are playing leading roles in supporting local PCNs. The role of place-based partnerships and/or ICSs is therefore likely to vary; in some cases they may play a direct role in delivering support to PCNs, while in others the partnership may play more of a co-ordination role, ensuring that there is appropriate support from other sources and that it is strategically aligned with the wider objectives of the place and system.

Principle six: Nurture joined-up resource management

Key points

- There are significant advantages to having some NHS budgets controlled at place. In the context of CCG mergers and proposals for them to be subsumed by statutory ICSs, there is a risk that these benefits will be lost.
- It will therefore be important for ICSs to develop arrangements for delegating some budgets to place level and to ensure that appropriate skills and expertise in planning and resource management exist at place.
- National bodies will need to support ICSs to develop processes to robustly and transparently allocate financial resources to place.
- Place-based partnerships can help create a more joined-up approach to resource management underpinned by shared priorities and an ethos of 'one place, one budget', even if they do not become budget-holding entities in their own right.

Why place-based resource management matters

Health services are commissioned over a variety of population footprints depending on the nature of different services. Over the coming years, ICSs will take on significant responsibilities for managing NHS resources and planning a range of health services, including taking on commissioning functions that currently reside with CCGs and some specialised services that have previously been directly commissioned by NHS England (Department of Health and Social Care 2021; NHS England and NHS Improvement 2018).

While supportive of ICSs playing a greater role in resource management, many stakeholders we spoke to argued that places also need to play a role in shaping how financial resources are used locally. In particular, interviewees pointed to a group of local health services that form the core of most people's health and care use, which are therefore central to the integration agenda at place. These commonly included community services, general practice and broader primary care services, with some suggesting this should also extend to elements of mental health budgets and some higher-volume hospital services. Managing budgets for these services at place could help to enable integration across them, and crucially support co-ordination with social care and other services commissioned by local authorities.

There is therefore a strong case for an NHS planning function at place level, which holds a budget for a spectrum of local health services. Advantages may include:

- enabling joint planning of health and care services, and potentially the pooling of NHS funds with local authority resources (for example, via the Better Care Fund or Section 75 agreements)
- developing a granular understanding of local population health needs and strengths and tailoring the use of resources accordingly
- building and nurturing relationships with VCS organisations; many are rooted in place, meaning that the development of financial arrangements to support these organisations is often best done at a local level
- facilitating a cross-sector dialogue; some interviewees noted that where commissioning operates most effectively it can work as a broker of local relationships and provide a neutral perspective among provider organisations.

This aligns with previous research by The King's Fund, which found that planning arrangements operating at place, enabled by a shared approach to risk and strong relationships among key stakeholders, can support local service integration (**Robertson and Ewbank 2020**).

The impact of changes to NHS commissioning structures

There has been a trend towards consolidation of NHS commissioning structures in recent years, with many CCGs coming together through joint management structures or formal mergers. This trend accelerated following publication of the NHS Long Term Plan, as this set an expectation that ICSs would 'typically' have a single CCG across their footprint (**NHS England and NHS Improvement 2019b**).

At the same time as moving to fewer, larger CCGs, local systems have been developing approaches to service planning at place. In the systems we looked at as part of this work, a variety of models were being used (*see* box).

Some merged CCGs, like Nottingham and Nottinghamshire, are organising some of their functions across a system-wide footprint and other functions around place footprints. Similarly, some parts of the country have developed models of resource

delegation to place while retaining oversight at system level. For example, some models involve a designated senior leader overseeing NHS resources at place level within a larger CCG, and in some cases, joint NHS/local authority appointments have enabled this to be twinned with responsibility for some local authority resources (for example, some boroughs of South East London are developing place-based CCG/local authority leadership roles that support this).

Models of resource planning at place in example systems

- In Nottingham and Nottinghamshire, which completed its CCG merger in April 2020, there is a focus on developing a programme budget approach whereby place-based partnerships take on responsibility for shaping portfolios of NHS services and drive service integration through contracting with lead providers. For example, in Mid-Nottinghamshire there is a developing provider collaborative for musculoskeletal services.
- In North East Essex, the place-based partnership, or Alliance, has focused on overseeing and shaping greater co-ordination of local spending (including Better Care Fund monies and Section 75 agreements) spanning a broad range of local health and care services, but with North East Essex CCG remaining the formal NHS budget-holder.
- West Yorkshire and Harrogate ICS had so far retained separate CCGs for its places, so the bulk of NHS resource continued to flow to place by default. Over recent months, the system has undertaken an exercise to develop its future model of commissioning, including the functions needed at place. The work at place is likely to focus on developing the interface with local authorities, deepening joint service planning across health and care, and developing a model of commissioning at place that focuses on promoting local collaboration with provider organisations.

More recently, national policy has shifted from encouraging CCGs to merge to mandating them to do so. NHS England and NHS Improvement's integrating care proposals set a date of April 2022 as the effective deadline for all ICSs to merge their CCGs to be coterminous with system footprints. Subsequently, the government White Paper reiterated that CCGs will merge to system footprints, and proposed that their functions would be subsumed by ICSs as they become

legal entities. But both documents also emphasised the importance of place and suggested that some resource management should be delegated to this level.

- NHS England and NHS Improvement's integrating care document says ICS leaders will be expected to use new financial freedoms to delegate 'significant budgets' to place, which might include resources for general practice, other primary care, community services, and continuing health care (**NHS England and NHS Improvement 2020**, p 18).
- The government White Paper says that ICS NHS bodies will be able to delegate significantly to place level, including by aligning their allocation functions with place (for example, through joint committees), but suggests this will be left to local determination. It also highlights options for strengthening integrated commissioning across the NHS and local government through the Better Care Fund and pooled budget arrangements (**Department of Health and Social Care 2021**, p 35).

How budgets could be delegated to place in this developing landscape

As place-based partnerships will not be legal entities able to hold budgets in their own right, there are a number of practical questions about how these aspirations can be realised. In practice, it will be internal delegation within ICSs that enables NHS resources to flow to place and allows joint planning with local government at this level. This reinforces the case for ICSs to structure themselves (or parts of their functions) around place-based geographies.

ICSs will need to develop arrangements appropriate to their local context. Options might include creating place-level sub-committees of the ICS NHS board to formally oversee delegated resources. Designated senior leaders could be appointed for each place, with these individuals effectively accountable for the NHS financial resource delegated to each place, reporting into the ICS chief executive (the overall accountable officer formally responsible for the ICS's resources).

Alongside these structural arrangements, ICSs will need to ensure that capabilities and expertise previously held in CCGs are deployed to support effective planning and resource management at place. Key functions may include data analysis, needs assessment, negotiation and facilitation, and evaluation skills. This does

not necessarily mean that ICSs should recreate a full spectrum of commissioning capabilities at place, as it may be more appropriate and efficient for some of these functions to sit centrally (or with partner organisations), but ICSs will need to consider how these capabilities can be made available to their constituent places.

While there is some experience of merged CCGs organising themselves around place, these arrangements are generally new and evolving. There is therefore much to be worked through to enable statutory ICSs to meet the objective of delegating significant budgets to place. Guidance and ongoing support will be needed to spread learning and help overcome hurdles as they arise.

Subdividing a portion of ICS budgets to place level raises potentially complex technical questions about financial allocations, particularly how population needs can be reflected and how to ensure equity (**Anandaciva and Murray 2020**). Much of the expertise in NHS financial allocations resides with NHS England and NHS Improvement, so they will have an important role to play in supporting ICSs to navigate these technical questions. There is also a strong case for ICSs to ensure transparency around their internal allocation process, as NHS England and NHS Improvement has with the national allocation formula.

Once ICSs have developed mechanisms to delegate some NHS resources to place, there are a range of ways that these can be aligned with local authority resources to support joint planning and delivery of health and care services. This includes Section 75 agreements, the Better Care Fund, lead commissioner models, shared NHS/local authority leadership arrangements, and individual service user budget-pooling through personal health and social care budgets (**NHS England and NHS Improvement 2019b**).

Moving towards a place-based ethos of resource management

While the work of place-based partnerships could be supported by having some budgets delegated to the level of place, it is unlikely that the partnerships themselves will become budget-holding entities. Rather, their priorities and cross-sector planning approach will shape the commissioning decisions of the constituent organisations. Budgets flowing to place is no guarantee of positive impact; traditional commissioning approaches could see existing patterns of service delivery maintained. It will be the strength of the local agenda and collaborative

ways of working across partners at place that will determine whether this drives service change.

This reinforces the need for place-based partnerships to develop shared priorities that support a joined-up approach to make best use of the total collective resources available to improve health and wellbeing. Some of the stakeholders we spoke to described working towards a mindset of 'one place, one budget' as the ethos they were attempting to cultivate within their partnerships.

Principle seven: Strengthen the role of providers at place

Key points

- Much of the work required to deliver more integrated services needs to happen at place level through closer collaboration between providers of all kinds.
- Larger providers such as hospital trusts need to be able to engage in place-based collaboration at the same time as pursuing closer integration with neighbouring trusts through collaboratives covering larger geographies. Provider collaboration within places serves a different purpose to provider collaboratives covering whole systems, and both forms of collaboration will be needed.
- Relationships between providers can be strengthened through a range of mechanisms that do not require organisational restructuring or contractual changes; these approaches should be explored first before attempting to formalise new forms of collaboration.
- It is likely that a range of overlapping collaborative arrangements will be needed involving different providers working together in different ways – for example, to co-ordinate services around specific pathways or population groups.
- While all providers need to be able to engage in place-based work, the model for doing so will vary depending on the nature of the services they deliver and the size of the geography they serve.

A significant focus for partnerships at place level is redesigning the delivery of health, social care and other public services. Given this, it is important that health and care providers of all kinds are closely engaged in place-based working. It is through collaborative working at this level that much of the work required to deliver more integrated services and to improve population health will be done.

Collaboration at multiple levels

'Provider collaboratives' are set to become a key part of the emerging arrangements in the NHS over the next few years. NHS England and NHS Improvement (2020) set out two distinct ways in which providers need to be working together to join up the provision of services:

- *Collaboration within places.* Place-based collaboration is needed to improve co-ordination across service boundaries (primary/secondary, mental/physical, health/social care), with a focus on redesigning care pathways that straddle multiple organisations and enabling more care to take place in community settings. This needs to involve a broad range of organisations, including primary care, hospital providers, mental health trusts and VCS organisations.
- *Collaboration between places.* This form of collaboration involves providers working together across a wide geography with other similar organisations to improve the quality and efficiency of services they provide. The focus is typically on sharing resources and expertise between trusts, achieving economies of scale, standardisation of care, sharing back-office functions, and taking co-ordinated action on systemic issues such as workforce.

Collaborative working between providers greatly accelerated as part of the response to the Covid-19 pandemic, and there is a clear desire among policy-makers to build on this (NHS England and NHS Improvement 2020). Further guidance elaborating on national expectations will follow later in 2021.

It is important that larger providers such as hospital trusts are able to engage in place-based collaboration at the same time as pursuing closer integration with neighbouring trusts through collaboratives covering larger geographies. For place-based partnerships to thrive, hospital providers will need to be willing to work differently with primary care and community-based organisations, reaching into the communities they serve – building on the shift in focus that some hospital providers have been making over several years (Naylor *et al* 2015).

In our research we encountered some concern about the capacity of hospital trusts and other large providers to 'look both ways' in this way. However, there are precedents which illustrate that it is possible for providers to engage in both

agendas. For example, South West Yorkshire Partnership NHS Foundation Trust hosts a place-based mental health alliance in Wakefield involving a range of partners (spanning NHS providers, commissioners and the voluntary sector) while also participating in a mental health provider collaborative with neighbouring mental health trusts across a much larger area.

While all hospital providers need to be able to engage in place-based work, the model for doing so will vary. In smaller local hospitals that are more focused on place by virtue of their scale, the trust chief executive may choose to be directly involved in the local place-based partnership board. In contrast, large teaching hospitals providing highly specialised services may need to find a different model of engagement, potentially having nominated senior leaders with responsibility for integrated place-based delivery. For example, Nottingham University Hospitals NHS Trust has appointed a director of integration who sits on the boards of the two ICPs the trust is involved in.

Hospitals as 'anchor institutions'

An important way provider organisations can contribute to place-based working is through their role as employers and purchasers of goods and services. There is a growing list of examples of NHS hospitals and other organisations acting as 'anchor institutions' in their local community – for example, by targeting employment opportunities at people living in areas with high levels of economic deprivation. By doing so, providers can play a role in tackling the wider determinants of health inequalities among the population they serve.

Supporting collaboration between providers at place level

To achieve their goals, place-based partnerships will need to foster collaboration between providers delivering services to the local population. There are a range of options for this, from looser networks and federations through to more formal partnerships. This may include developing an integrated care provider as a new vehicle for delivering better integrated services and some areas of England are considering using the integrated care provider contract developed by NHS England to support this (NHS England and NHS Improvement n.d.). While this may be a helpful

option for place-based partnerships to explore at some stage, many of the benefits of collaboration can be achieved more readily through less formal routes that do not require complex contractual innovation or organisational restructuring. A key lesson from NHS England's new care models programme was that relationship-building needs to take place before new ways of working are formalised through organisational or contractual changes (Naylor and Charles 2018; Collins 2016).

Various mechanisms can be used to support this much-needed relationship-building between providers, including creating joint posts across organisations, co-locating teams, agreeing a shared vision and creating a culture of transparency (Naylor and Charles 2018). These kinds of approaches were being used to bring providers closer together in some of the sites involved in our research. For example, Leeds Community Healthcare NHS Trust and Leeds GP Confederation share three executive-level posts (director of nursing, director of human resources (HR) and medical director). Through these joint posts and by finding opportunities to co-locate frontline teams involved in care delivery, the two organisations aim to support the development of more integrated community and primary care services.

Different forms of collaboration will be best suited to different needs and functions. It is likely that within a given place-based system, a range of overlapping collaborative arrangements will be needed – for example, to co-ordinate services around specific pathways or population groups. These collaborations would involve different providers working together in different ways, and with different degrees of formality. For this reason, we would caution against place-based partnerships attempting to identify a single contractual or organisational solution to underpin the entirety of the work the partners seek to do together.

In some cases, new forms of collaboration at place level will involve blurring the boundary between purchasers and providers. For example, the Wakefield mental health alliance described above has a role in planning, resource allocation and co-ordination, and some of the Wakefield CCG budget has been delegated to it. The Alliance has drawn up a memorandum of understanding setting out ways of working for participating organisations, and is held to account by the Wakefield integrated care partnership on a quarterly basis.

Principle eight: Embed effective place-based leadership

Key points

- Effective leadership is critical to achieving the opportunities of place-based partnerships described in this report.
- Our work has highlighted the power of multi-agency leadership teams that are able to co-ordinate change at place level, and work across different levels of activity within an ICS.
- Effective place-based leadership requires a leadership mindset that is supportive of collaboration.

The local systems we engaged with as part of this work varied in the choices they had made about how to organise their leadership capacity and capabilities, but all agreed that translating the aspirations of place-based working into tangible service change will depend on effective leadership at place.

A designated place leader

NHS England and NHS Improvement's document outlining next steps for ICSs and options for legislative reform specifies that each place will have a 'leader on behalf of the NHS' who will work with other partners to co-ordinate the work of bolstering primary care, integrating services and promoting good health (NHS England and NHS Improvement 2020). The details of how this role will be enacted have yet to be clarified.

Stakeholders we spoke to expressed mixed views about the value of a designated NHS leader for place. Some suggested this role could support the delegation and management of NHS resources at the level of place. Others felt it may be helpful for an individual to be responsible for bringing political, community, clinical and managerial leaders together especially if there was no existing forum, and that a designated place leader could act as an important point of contact for non-statutory partners. We heard from some parts of the country where there was already a designated place leader (for example, some London boroughs) that the role had strengthened and, in some cases, re-set relationships between leaders of local

statutory and non-statutory organisations. However, a number of questions were also raised, such as how this would be supportive of multi-agency working. We heard concerns that, depending on how the role was fulfilled in practice, an NHS place leader might drive an NHS-centric approach, undermining a sense of equal partnership at place. Many were keen for further clarity regarding the purpose of a designated NHS place leader.

The systems we looked at as part of this work were using different mechanisms to enable place-focused leaders to shape the agenda at system level. For example, some were ensuring that clinical, community and political perspectives from places were included on the ICS partnership board. The relationship between the place-based leader and/or place-based leadership forum and the ICS partnership board was seen as important.

There are a range of leadership functions that could be built into a leadership model at place. These will partly depend on local factors such as the role played by existing bodies such as health and wellbeing boards, as well as the relationship between the place and the ICS. Our work points to two key overall leadership functions that will be needed at place:

- responsibility for financial resources (as discussed in principle six)
- responsibility for convening and actively engaging in a multi-agency place-based leadership group.

While those responsibilities could be held by one person (for example, in the form of an NHS leader for place), our work suggests that the second could be discharged effectively by leaders from other local organisations, including local authorities or VCS organisations, or by a group of local leaders working collaboratively together.

Place-based leadership teams

All the sites involved in this research had chosen to bring together a multi-agency leadership team to drive forward their place-based agenda. For example, in Leeds, the Partnership Executive Group is made up of chief executives from all the key local health and care organisations – NHS, local government and the third sector. The chief executive from the local authority currently chairs the group and the chair

rotates every two years. Similarly, in North East Essex, a group of senior leaders from local organisations have formed a leadership team, each has been allocated areas of responsibility for partnership business (with other colleagues taking on responsibilities for operational issues and reporting to the core leadership team), and an independent chair has been appointed from the local VCS.

In these place-based leadership teams, local political, community, managerial and clinical leaders are involved. In some cases, they are part of the place-based executive leadership team, while in other instances some of these leaders wield their influence through the local health and wellbeing board (as described in principle four, links between health and wellbeing boards and place-based leadership teams vary).

Councillors, GPs and community leaders often live and work 'in place' and can have a great deal of knowledge about local economic and social issues. Some place-based leadership teams are exploring how they can use this knowledge and passion for place to deepen their relationships with local people and communities. In some ICSs, the involvement of local councillors, GPs and community leaders is also being actively developed at a locality/neighbourhood level.

Leadership style

Effective place-based leadership requires a more collaborative and facilitative style of leadership. Leaders will need to work together and not allow their organisational interests to dominate.

Adopting a joint problem-solving approach and collectively agreeing a way forward is fraught with challenges such as organisational politics and governance. It is time-consuming and often conflicts with traditional structures and processes. Experience shows that rivalry and disagreement over shared goals, a lack of understanding of each other's organisational constraints, and poor communication can be just some of the obstacles health and care leaders need to overcome. Other barriers to collaborative leadership stem from individual behaviours such as defensiveness, and ego. Leaders working collaboratively need to gain a greater appreciation of each other's organisational issues and may benefit from leadership and organisational development support designed to enable local implementation of collective endeavours.

At its best, collaborative leadership is about bringing together leaders with different views and perspectives and creating the conditions to allow issues to be discussed openly with challenge to find ways of working together to solve complex problems. For example, in one of the three place-based partnerships in Nottinghamshire, we heard that health and care leaders are working together with a broader group of partners drawn from housing and the police service to address the needs of homeless people more effectively. Constructive interpersonal relationships and a shared commitment to act were seen as being critical in the development of the new service. Leaders' ability to see the larger system and not to focus solely on organisational interests was also seen as important.

In the Suffolk and North East Essex ICS, the three place-based leadership teams have regular protected development time to stand back and think differently about the future together. They are shifting their focus from solely reacting to and resolving operational issues towards co-creating a future focused on key priorities such as reducing gaps in life expectancy locally.

In the sites involved in our research, NHS leaders involved in multi-agency place-based leadership teams spoke of the value of strengthening their relationships with colleagues from local government and the voluntary sector (as emphasised in principle three). In these leadership teams, there is a strong sense of 'we are in this together'. Leaders are taking on responsibilities for a range of programmes and projects across place, with roles assigned based on who is best suited for the role as opposed to which organisation they lead.

Effective place-based leadership teams are also designing strategies so that they can work more as a 'team of equals'. Some places are appointing independent chairs from outside of the NHS and local government to shift pre-existing power dynamics. In other instances, there is recognition that bringing in VCS leaders at an earlier stage would be beneficial in providing new solutions to complex local issues. There were also examples of leaders seizing opportunities to change their own organisational practices to promote greater connections across health and care organisations. Such actions send important messages to wider staff about the importance of collaborating across organisational boundaries.

Leadership capacity to engage in place-based leadership teams is critical and, in some cases, leaders have re-organised their own organisational structures and processes to allow them to invest more of their time on place-based activities. Others are seeing it as an important part of their leadership role. Most place-based leadership teams are adopting a distributed approach to enhance their leadership capacity by engaging a wider cross-section of staff groups.

4 Implications for policy and practice

As set out throughout this report, the success of place-based partnerships will largely rest on local implementation. However, larger systems and national NHS bodies also have an important role to play in enabling and supporting these efforts. In this section, we consider the implications of our findings for ICSs as they establish themselves and clarify their roles and structures, and for national bodies and regional teams as they approach the next stages of policy development and support for integrated care.

The next year will be a critical period for the development of ICSs. If current legislative proposals are enacted as planned, ICSs will be established as statutory entities in 2022. To undertake the roles and responsibilities expected of them, a concerted effort will be required to develop system working, both in terms of formal structures and governance, and the capabilities and relationships required to support them to function effectively. A supportive national policy environment will be needed for local systems to realise the full potential of multi-agency working at place.

All of this will be taking place within the context of restoring and recovering services in the wake of Covid-19. This will involve ongoing measures to control the virus, addressing the substantial backlog of elective care, tackling the less visible backlog in community-based services, and supporting people whose physical and mental health have deteriorated. Recovery efforts will also need to tackle the deep health inequalities that have been exacerbated by the pandemic and the wider social and economic damage it has inflicted. Recovery will require a long-term, system-wide response from a wide range of partners in the NHS, local government and beyond. ICSs and the place-based partnerships within them will have a critical role in these efforts.

What are the implications for local systems and national policy implementation?

Proposals from NHS England and NHS Improvement have set a clear direction of travel for ICSs, including the expectation that partnerships at place will be a key building block. But there remain important questions about how local systems can make this work in practice and how national NHS bodies and regional teams can support place-based working to flourish. Our work highlights a number of issues they should consider as they approach the next stages of development.

- **ICSs must build up from the work of local place-based partnerships.** Whatever the potential of ICSs to co-ordinate strategic planning and deliver benefits of scale, much of the work involved in integrating care and improving population health will need to be driven by commissioners and providers collaborating over smaller geographies through place-based partnerships and local neighbourhood teams. Some advanced systems have successfully nurtured an approach where the ICS is built up from its constituent places rather than functioning as a separate entity. ICSs should now seek to embed this model by prioritising and supporting the development of their local places, ensuring that they are adequately represented in formal ICS structures and strengthening connections between arrangements and leaders at system and place. National and regional bodies need to be realistic about what can and should sit at system level. Importantly, policy-makers must resist setting ICSs up in a way that drives a hierarchical relationship, with places 'reporting into' ICSs. This risk will partly depend on how the roles and responsibilities of the proposed place-based leader for the NHS are conceived, on the style of leadership of individuals in leadership roles at place and at system, and on the expectations and behaviours of national NHS bodies. In addition, while the proposed duty for ICSs to 'have regard to' JSNAs and joint health and wellbeing strategies produced by health and wellbeing boards is welcome, this could be strengthened to set an expectation that ICS plans will be built up from these place-based plans.
- **Systems need to retain a local focus that balances national and local priorities.** If they are to become statutory bodies with formal responsibilities for NHS resources and performance, then ICSs cannot simply act as an aggregation of their constituent places. While their role in supporting and building from partnerships at place is key, ICSs will also need to manage upwards accountabilities through regional and national NHS structures. ICS leaders

will therefore need to be mindful of their responsibilities to deliver national priorities while balancing these with the characteristics and priorities of their local places. When places come together with partners across their ICS, they will need to recognise and work with their differences to create constructive dialogue rather than conflict. Managing the tensions that will inevitably arise at the interface between statutory ICSs and non-statutory place-based partnerships will not be easy, and is likely to be something that systems and places will need ongoing support with over the coming years.

- **To enable continued flexibility for locally led change, arrangements must be designed to support transparency and accountability across the health and care system.** National policy around ICSs has so far allowed a degree of flexibility to enable systems to work with their local characteristics and strengths. While the requirements around ICSs themselves are becoming more prescriptive, arrangements at place remain largely open to local determination. This creates both an opportunity and a risk. The opportunity is that partnerships can be tailored to the characteristics and priorities of a local place and design solutions that make the best use of local assets, and that this engenders a sense of ownership among local partners. The risk is that the variation in arrangements across the country is confusing and makes it difficult to navigate decision-making structures. This tension is at the heart of decisions about how to balance national direction and local autonomy as the health and care system evolves. Policy-makers should hold their nerve in supporting locally led change, learning from the failure of previous top-down approaches to NHS reform, while setting clear minimum expectations around appropriate governance and transparency. In turn, ICSs and place-based partnerships have a responsibility to clearly and openly communicate their arrangements to help people understand who does what.
- **Efforts should be made to nurture different forms of accountability.** It is essential to retain formal accountability mechanisms within publicly funded systems such as the NHS. Alongside this, other types of accountability relationships can be powerful drivers to improve the quality and delivery of services. Partnerships at system and at place should seek to embed mutual accountability through peer-to-peer challenge, and outwards accountability to communities through direct involvement of local people in governance structures and greater connectivity into local democratic structures such as health and wellbeing boards and overview and scrutiny committees. Embracing

these opportunities could help to bridge some of the longstanding disconnect between accountability mechanisms in the NHS and local government, and strengthen links with local communities.

- **ICSs and place-based partnerships should prioritise the relational aspects of their development.** There is a large volume of evidence that relationships between leaders within systems are the most powerful drivers of transformational change (Collins 2019; Senge *et al* 2015). While a range of formal mechanisms (including governance structures and contractual approaches) may be used to underpin collaborative working, these should be seen as supporting mechanisms rather than an end in themselves. National leaders should resist the temptation to design a uniform organisational form for place-based partnerships, recognising that they are not new organisations but are a new way of working across organisations. The success of ICSs and place-based partnerships will require investment in organisational development and sustained commitment from leaders to develop collaborative relationships at all levels. If proposals for a designated NHS leader at place are taken forward, these will stand the best chance of success if individuals in these roles operate as part of a wider multi-agency leadership team, and model the collaborative, facilitative style of leadership outlined in this report.
- **National and regional NHS bodies should further develop their approaches to support place-based working.** Regulators will need to continue to offer assurance on quality and performance but will increasingly look at this on a system level and work with and through ICSs to support improvement. They will need to develop constructive approaches to working with ICSs and avoid pushing them into a hierarchical relationship with their local places. This means working with ICS leaders to understand local challenges and supporting systems to drive change from within. It will also require national and regional bodies to avoid overloading ICSs with central asks or using heavy top-down performance management that could cause unhelpful behaviours to permeate through the system. The scale of cultural and behavioural change this will require should not be underestimated.
- **It is critical to embrace and strengthen the role of local government at system and at place.** It will not be possible to deliver the ambitions of integration and population health without the full involvement of local authorities in these efforts. The proposal to establish an ICS health and care partnership alongside the ICS NHS body is an attempt to address concerns about whether it will be

possible for ICSs to function both as statutory NHS bodies and as wider system partnerships. Many questions remain about how the relationship between these two bodies will work in practice and the role and level of influence of local government on each, and this will require close attention as the proposals are further developed and implemented. Whatever the outcome, it will be more critical than ever for work at place level to support genuine equal partnerships, with local government not just involved but jointly driving the agenda.

- **Clinical involvement and leadership should be built into new collaborative decision-making structures.** There is evidence that clinical involvement in the planning of local health and care services can support innovation (Robertson and Ewbank 2020). The proposed changes to CCGs will unpick the model of clinical leadership envisaged by the 2012 Health and Social Care Act, meaning that systems must now find ways to retain and deepen clinical involvement in the new collaborative decision-making structures being created. Through the work of ICSs and place-based partnerships, there is an opportunity to broaden involvement to a wider range of clinical staff and other professionals working on the wider determinants of health to support the shift to population health.
- **National guidance is needed to clarify key elements of the future NHS landscape and how it will support the work of place-based partnerships.** The recent White Paper and guidance from NHS England and NHS Improvement set out a framework for the future health and care system, with partnerships at place being central to this. However, there are a number of important questions about how the different elements of the changing health and care landscape will fit together. These include the following.
  - What the relationship will be between provider collaboratives at system level and provider collaboration at place. The policy focus on NHS provider collaboration at scale must not prevent providers from giving adequate time and attention to place-based collaboration.
  - How effective resource management at place will be supported. More information is needed on the infrastructure and mechanisms that can be used to manage NHS resources at place as CCGs merge and move into new ICS structures. In addition, government departments – in particular the Department of Health and Social Care, the Ministry of Housing, Communities and Local Government, and HM Treasury – could come together to consider the implications of aligning different elements of public spending across a place and how this can be supported.

- **The current reforms must be given sufficient time to embed and opportunity to succeed.** Evidence from previous attempts to integrate care indicates that these changes will take time to deliver results. This means that local and national leaders need to make a long-term commitment to the development of ICSs and place-based partnerships and avoid past mistakes of moving swiftly to the next reorganisation if desired outcomes are not rapidly achieved. Not only would this be disruptive, but it would risk wasting effort and losing goodwill among local government and other partner organisations, many of which have already invested significant time and resources into making ICSs and place-based partnerships work. There should be a focus on incremental change, progressively strengthening partnerships and delivering tangible improvements for communities.

Appendix: Methodology

This report is informed by a number of strands of insight and draws on research conducted between August and November 2020.

Initially, we conducted a rapid review of published literature, both academic and grey, exploring place-based working in public services. This was complemented by scoping conversations with expert stakeholders (n=20), spanning system leaders, national policy-makers and stakeholder organisations, to identify key issues and areas of interest.

These conversations, and The King's Fund's wider work with ICSs around the country, helped to identify three example systems. These were selected based on two key criteria: that their approach to place-based working was sufficiently developed to be of interest to a wider audience; and that they spanned a range of geographical and organisational contexts. In particular, the systems were selected to include a mix of rural and urban settings, and a combination of unitary and two-tier local government arrangements. The systems were:

- Nottingham and Nottinghamshire
- Suffolk and North East Essex
- West Yorkshire and Harrogate.

In each system we reviewed relevant documentation, including strategy documents and governance arrangements. We carried out in-depth interviews (n=26) with stakeholders from a range of organisations, including NHS providers and commissioners, local authorities, and the voluntary sector, to understand their approach to working through place-based partnerships, and the relationship of this to the work of local organisations, neighbourhoods and ICSs. Interviews were conducted and recorded remotely; participants were assured anonymity and their insights have been analysed accordingly.

To build on insights from these example systems, we convened three virtual roundtable discussions with participants (n=42) drawn from local government,

VCS organisations and social enterprises. Attendees were selected with a view to understanding the views of non-NHS partners operating in areas of England outside our three example systems. These roundtables were held in partnership with National Voices and the Local Government Association, and discussion focused on barriers and enablers to effective multi-agency working at place.

We also sought to test and triangulate our findings with a wider group of stakeholders. We engaged with executive leads and independent chairs from ICSs and STPs in England via two remote events, convened by NHS England and NHS Improvement, and the NHS Confederation. Discussion focused on exploring key challenges and issues raised in our findings to date, with a particular focus on how systems can support place-based working. Lastly, we conducted a small number of focused interviews with local and national leaders (n=5) with specific experience and expertise – for example, in relation to supporting the development of PCNs.

All data generated was stored confidentially and analysed thematically.

The King's Fund was commissioned by NHS England and NHS Improvement to support their policy development over the second half of 2020, focusing on how place-based partnerships are forming and operating within ICSs and how this can be supported. This commission funded the research activities described above. The evidence and insights gathered were used to inform the insights that The King's Fund shared with NHS England and NHS Improvement, as well as to inform the arguments set out in this report. However, the report itself has been produced independently by The King's Fund and draws on our wider body of work. The views expressed are those of the authors.

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The King's Fund Ideas that change health and care

Major changes are taking place in the way health and care is organised in England, with integrated care systems now established in all areas of the country. Much of the heavy lifting involved in integrating care and improving population health is happening more locally, with placed-based partnerships playing a key role in driving change. But what does working at place really mean, and how can the development of place-based partnerships be supported?

Drawing on existing evidence and literature, interviews in three example systems and engagement with leaders in the NHS, local government and voluntary and community sector, The King's Fund sought to better understand the potential role and contribution of place-based partnerships and explore how they are forming in practice.

This report outlines the key functions of place-based partnerships and identifies eight principles to help guide their development:

- start from purpose, with a shared local vision
- build a new relationship with communities
- invest in building multi-agency partnerships
- build up from what already exists locally
- focus on relationships between systems, places and neighbourhoods
- nurture joined-up resource management
- strengthen the role of providers at place
- embed effective place-based leadership.

The report concludes by highlighting the implications for ICSs as they establish themselves and clarify their roles and structures, and for national bodies and regional teams as they approach the next stages of policy development and support for integrated care.

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