Place-based partnerships explained

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Place-based partnerships are collaborative arrangements between organisations responsible for arranging and delivering health and care services and others with a role in improving health and wellbeing. They are a key building block of the integrated care systems (https://www.kingsfund.org.uk/publications/integrated-care-systems-explained) (ICSs) recently established across England and play an important role in co-ordinating local services and driving improvements in population health.

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What are place-based partnerships?

There are currently around 175 place-based partnerships in England, typically covering populations of around 250–500,000 people (although this varies widely) – significantly smaller than the populations covered by ICSs. While ICSs can bring the benefits of working at scale to tackling some of the major strategic issues in health and care, smaller place-based partnerships within ICSs are better suited to designing and delivering changes in services to meet the distinctive needs and characteristics of local populations.

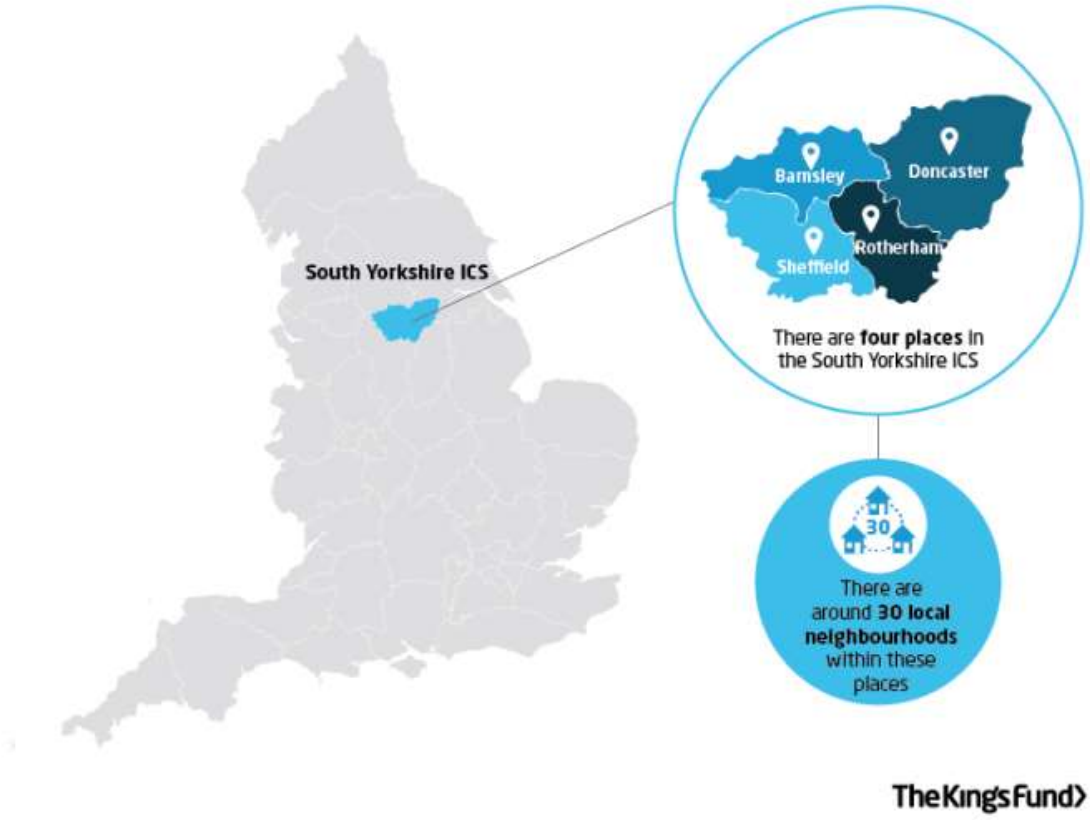
Place-based partnerships often (although not always) match the area covered by an upper-tier or unitary local authority (https://www.newlocal.org.uk/articles/local-government-explained-types/) . This means that in many areas, place is the level at which most of the work to join up budgets, planning and pathways for health and social care services will need to happen.

Place-based partnerships typically involve the NHS, local government and other local organisations with responsibilities for planning and delivering services, such as voluntary, community and social enterprise (VCSE) sector organisations and social care providers. They may also include or work alongside other community partners with an influence on health and wellbeing, such as schools, emergency services and housing associations, and work with people who use services, their carers and local residents.

Unlike ICSs, place-based partnerships are not statutory bodies. The 2022 Health and Care Act (https://www.kingsfund.org.uk/publications/health-and-care-act-key-questions) (which formalised ICSs as legal entities with statutory powers and responsibilities) did not create any legal requirements for place-based partnerships, leaving flexibility for local areas to determine their form and functions. This flexibility is welcome and necessary given that the characteristics and capabilities of place-based partnerships vary widely across the country.

Within places, even more-localised arrangements are being established around 'neighbourhoods' (https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/), where multi-agency teams can come together to deliver better joined-up, proactive and personalised care, building on the work of primary care networks (https://www.kingsfund.org.uk/publications/primary-care-networks-explained).

Figure 1 An example of the places and neighbourhoods within an ICS



What is the purpose of place-based partnerships?

Place-based partnerships exist to make more effective use of the combined resources available within a local area. The specific priorities of each place-based partnership will vary depending on the vision and goals agreed locally by partners. There are a number of common functions (as described in our report, Developing place-based partnerships (https://www.kingsfund.org.uk/publications/place-based-partnerships-integrated-care-systems)), including understanding and working with communities, joining up and co-ordinating services, addressing the social and economic factors that influence health and wellbeing, and supporting the quality and sustainability of local services (see Figure 2). These functions reflect the ways in which place-based partnerships have the greatest potential to add value over and above the contributions of individual organisations or entire systems.

Figure 2 Key functions of place-based partnerships

Understanding and working with communities	1. Developing an in-depth understanding of local needs 2. Connecting with communities

Joining up and coordinating services around people's needs

3. Jointly planning and coordinating services
4. Driving service transformation

Addressing social and economic factors that influence health and wellbeing

5. Collectively focusing on the wider determinants of health
6. Mobilising local communities and building community leadership
7. Harnessing the local economic influence of health and care organisations

Supporting quality and sustainability of local services

8. Making best use of financial resources
9. Supporting local workforce development and deployment
10. Driving improvement through local oversight of quality and performance

Place-based partnerships need to focus on activities that complement the work of their ICS and vice versa. In principle, the 'system' tier focuses on strategic planning, overseeing overall resources and performance, planning specialist services and driving strategic improvements in areas such as workforce planning, digital infrastructure and estates. In contrast, place-based partnerships tend to be more focused on delivering tangible service change and engaging directly with communities – particularly in relation to community services, social care and primary care, and to tackle the wider factors that influence health and drive inequalities (*see* box below).

The exact balance of functions across system, place and neighbourhood levels will vary depending on local circumstances, meaning there is no simple answer to exactly which activities will sit at which level (and on many issues, complementary activity will be needed across all levels).

Examples of work led by place-based partnerships

- The Bradford District and Craven Health and Care Partnership (https://bdcpartnership.co.uk/transformation-programmes-our-year-in-review-2021-2022/) is delivering eight transformation programmes from 'Better Births' to 'Ageing Well'. One of these, the 'Healthy Hearts' programme, has seen VCSE sector organisations working closely with GPs to deliver health checks in community settings, enabling better uptake among people who have historically faced barriers in accessing preventive services.
- Nottingham City Place-Based Partnership (https://healthandcarenotts.co.uk/care-in-my-area/nottingham-city-pbp/priorities-programmes/) 's work includes a programme focused on 'severe multiple disadvantage' (living with a combination of homelessness, substance use, mental ill health, contact with the criminal justice system and domestic abuse). Central to this is a focus on sharing local intelligence – both to better identify people who may benefit from a more coordinated package of support and to encourage the delivery of preventive services to reduce the likelihood of needs escalating.
- The Healthier Wigan Partnership (https://healthierwigan.nhs.uk/), established in 2018, aims to prevent illness by joining together health and social care services and giving local people the best opportunity to look after their own wellbeing. It has a particular focus on working more closely with communities by spreading the asset-based approaches developed through the Wigan Deal (https://www.kingsfund.org.uk/projects/lessons-wigan-deal).

What is a 'place'?

In most cases, places are based on local authority boundaries. This is particularly common where unitary authorities exist.

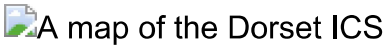
South East London ICS

South East London ICS (which covers a population of around 1.9 million people) is made up of six places, co-terminous with the six borough councils.


A map of South East London ICS

[Dorset ICS]

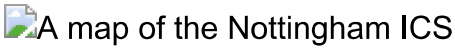
Dorset ICS (covering a population of around 800,000) has two constituent places, each co-terminous with a unitary authority.


A map of the Dorset ICS

In other systems, the relationship between place and local authority boundaries is less straightforward. Place footprints might instead be established around clusters of district councils, the area served by a hospital or established groupings already being used for joint working across the NHS and local government.

[Nottingham and Nottinghamshire ICS]

Nottingham and Nottinghamshire ICS (which covers a population of around 1.2 million people) consists of four places, and spans two upper-tier local authorities – the unitary city council and the two-tier county council. One place is co-terminous with the city council, one is co-terminous with a district council and the other two each cover several of the six remaining district councils (roughly aligning to patient flows into the two acute providers).


A map of the Nottingham ICS

[Suffolk and North East Essex ICS]

Suffolk and North East Essex ICS (which covers a population of around 1 million people) consists of three places and spans two upper-tier local authorities – most of Suffolk County Council and part of Essex County Council. The places are based around established organisational footprints (reflecting the previous boundaries of clinical commissioning groups (CCGs) and patient flows around acute hospital providers). Each place covers more than one lower-tier local authority.


A map of Suffolk and North East Essex ICS

Even within a single ICS, places can vary widely in their size, population and complexity (although they cannot span ICS boundaries). This variation has implications for the capabilities and challenges across different place-based partnerships.

What are the expectations and requirements in national policy and guidance?

Place-based partnerships have existed in various forms for many years, supported by a range of national and local initiatives (https://lankellychase.org.uk/publication/historical-review-of-place-based-approaches/) designed to enable cross-sector working at place (many of which have been led by local government). There is now a renewed push to strengthen place-based partnership working as part of the integration reforms associated with the 2022 Health and Care Act.

While the Act itself includes no legal requirement to create place-based partnerships, it does allow for integrated care boards (ICBs) to establish place-based sub-committees and to delegate some of their functions and budgets to these committees. Thirty-nine of the 42 ICSs established across England have chosen to operate through a place sub-structure, and there is an expectation that they will delegate some of their functions to this level. ICBs will remain formally accountable for any functions and resources they delegate in this way.

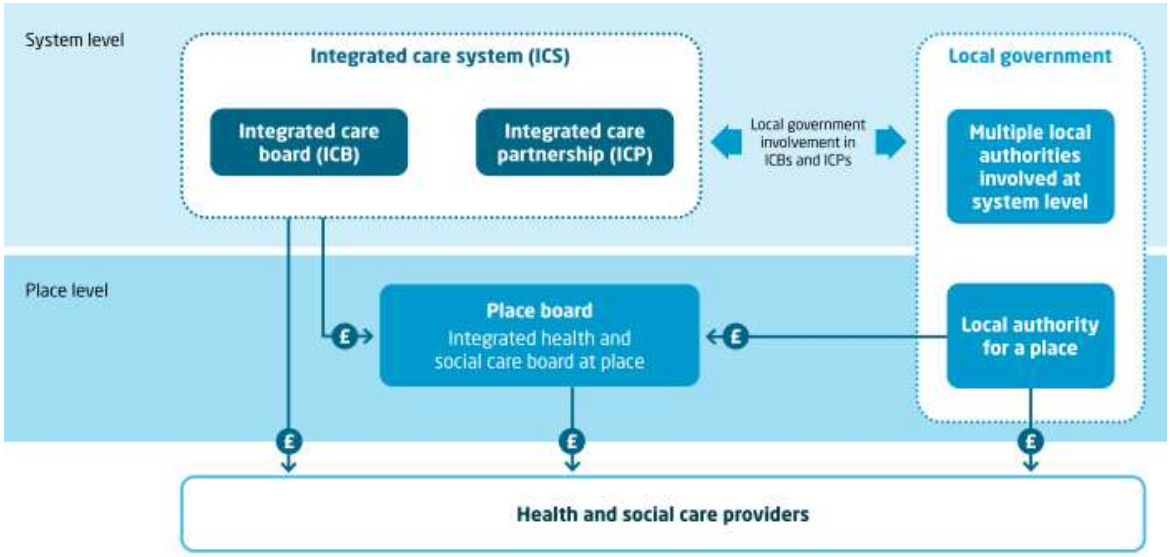
Further guidance on the expectations for place-based partnerships has been set out in national policy and guidance, in particular in *Thriving places* (https://www.england.nhs.uk/publication/integrated-care-systems-guidance/) (joint guidance from NHS England and the Local Government Association) and the government's integration White Paper (https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations). These set clear expectations that ICSs should delegate significant responsibilities and budgets to place-based partnerships. Neither document attempts to prescribe the allocation of functions between system and place, acknowledging that this will depend on local circumstances, but recommend that this is guided by the principle of subsidiarity (meaning decisions should be taken as close to local communities as possible, with ICSs only taking on functions that benefit from working at scale).

The integration White Paper published in February 2022 aimed to strengthen governance and accountability arrangements at place level, including through an expectation that all places should develop a clear and transparent governance model meeting a core set of requirements (*see* below). The change of government means it is now uncertain which of the proposals in the White Paper will be taken forward.

How are place-based partnerships governed and led?

All place-based partnerships are required to have robust governance arrangements in place for their work. A common arrangement is to have a board or committee to which local authorities and ICBs can delegate some of their functions and budgets – referred to in the integration White Paper as a 'place board' (see below). Partnerships have freedom to develop alternative governance models that fit local circumstances provided these meet a set of minimum expectations, including clear decision-making processes and arrangements for resolving disagreements.

Figure 3 The place board model, adapted from the integration White Paper



Many places have developed governance structures close to the 'place board' model, often building on pre-existing local arrangements. For example, in North Central London, each place-based partnership has an executive group providing strategic leadership (comprising senior executives of local partner organisations) and a delivery board reporting to it, building on established structures developed locally over several years.

Many places have appointed a single place lead accountable to both the ICB and the local authority (or authorities) – in line with one of the proposed requirements in the integration White Paper. The role of the place lead includes representing the place in system-level conversations, and they often sit as board members of the ICB. Place leads usually also hold other leadership roles in one or more of the local partner organisations, including chief executives of local authorities (eg, Calderdale), directors of public health (eg, Bromley), directors of adult social care, or senior leaders from mental health trusts (eg, Southwark) or acute trusts (eg, Croydon and Bolton).

The role of the wider senior leadership team around the place lead is critical. For example, in Leeds there is a nominated place lead (the local authority chief executive) but there is also an agreement that leadership of the partnership work should be a collective endeavour involving chief executives from across the local health and care system rather than being the sole responsibility of the place lead.

Place leads are also usually supported by a team responsible for delivering the partnership's objectives. The size and nature of these teams varies considerably and is likely to change over time. In some places there is a substantial team accountable to the place lead, employed by the ICB. Elsewhere, there is only a very minimal core team underpinning the place-based partnership, with partner organisations expected to make additional staff time available to support delivery of agreed objectives.

What resources do place-based partnerships have at their disposal?

Place-based partnerships vary in terms of the resources they control directly, and those they are able to influence.

National guidance encourages ICBs to delegate some of their resources and responsibilities to place-based partnerships – recognising the fact that much of the work needed to integrate services, improve population health and tackle inequalities needs to happen at a more local scale. The extent to which this is happening at present is very variable, in part reflecting the different levels of maturity of partnerships across the country and the varying arrangements that ICBs inherited from the CCGs that came before them.

West Yorkshire ICS has adopted a maximum delegation approach, in which almost all the ICB's £5 billion budget is being put under the control of its five place committees (covering the same footprints as the CCGs that were responsible for local NHS budgets before July 2022). Commensurate with this high level of responsibility at place level, most of the ICB's staff are part of place-based teams, although many also have responsibilities straddling more than one place.

Some ICSs are pursuing a more targeted approach to resource delegation, and in others there are ambitions to delegate ICB budgets in future but currently no concrete arrangements for doing so.

The approach taken in some ICSs is to work in partnership with providers to bring together resources at place level. For example, in Greater Manchester, the bulk of NHS budgets will flow directly from the ICB to providers and those providers will then come together with local authorities, voluntary sector organisations and

wider public service partners in place-based ‘locality boards’. The locality boards operate with the principle of joint stewardship of the total resource for the population.

Place-based partnerships also aim to shape how a broader set of resources are used to improve health and wellbeing. A key function is to look across the range of resources available in the NHS, local authorities and elsewhere – including budgets, staff, data and estates – in order to improve how these are used to meet local needs. The ethos of ‘one place, one budget’ is more advanced in some areas than others but has become a key aspiration in many places, and the government has indicated that it would like to support local partnerships to go further in terms of pooling local authority and NHS budgets through ‘section 75’ arrangements and the Better Care Fund (https://www.kingsfund.org.uk/topics/better-care-fund) .

How do place-based partnerships relate to health and wellbeing boards?

Since 2012, all upper-tier local authorities in England have hosted a health and wellbeing board (https://www.kingsfund.org.uk/publications/health-wellbeing-boards-explained) (HWB) – statutory committees responsible for assessing local health and care needs and agreeing a health and wellbeing strategy. How these relate to place-based partnerships depends to a large extent on whether ‘places’ align with local government boundaries.

In areas where each place-based partnership covers the same population as a single HWB, there can be a close relationship between the two and complementary roles. For example, in Nottingham partners have agreed that the role of the HWB is to set the strategic priorities and the place-based partnership is then responsible for overseeing the delivery of this strategy, reporting to the HWB on a regular basis.

In other areas there are multiple place-based partnerships operating within a single HWB area. For example, in Essex the intention is that the joint health and wellbeing strategy for the county provides a strategic framework for places to work within, allowing for some flexibility to tailor the priorities to the specific needs of each place – informing rather than determining their work. The HWB also sees itself as having a role in sharing ideas and learning across places within Essex.

Whatever the arrangements agreed locally, the 2022 Health and Care Act is clear that that all ICBs – and by extension, place-based partnerships – have a responsibility to pay regard to local health and wellbeing strategies in developing

their plans. A key challenge is ensuring HWBs and place-based partnerships are complementary and avoid duplicating functions.

What next?

The development of place-based partnerships is a work in progress – they are evolving, and some are much more advanced than others. The ambition in most areas is for these partnerships to take on greater responsibilities over time.

It remains to be seen how the relationship between place-based work and system work led by ICSs will play out. If successful, place-based partnerships and ICSs are an opportunity to make a reality of the 'systems within systems' (https://www.kingsfund.org.uk/publications/place-based-systems-care) approach The King's Fund has argued for, combining the benefits of localism with the benefits of scale.

There are still important questions about how place-based partnerships will function in practice when formal, legal accountability sits elsewhere with ICB leaders and councils: how they will have the influence they need; whether they will be able to encourage and support service providers to work in a place-based way; and how they will be held to account for delivery.

The real test for place-based partnerships will be whether they can help to deliver the improvements needed locally – in particular, whether they can support the development of new models of service provision that give people a better experience of care, improve the health of the population and reduce inequalities. To do this they will need to work closely both with providers of health and social care services and with the communities they serve (https://www.kingsfund.org.uk/publications/communities-and-health).

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