The King's Fund

Ideas that change health and care

Place-based partnerships

Challenges and opportunities

Shilpa Ross
Nicola Blythe
Joni Jabbal
CJ Nwasike

April 2025

About this project

This research project was funded by the National Institute for Health and Care Research (NIHR) Policy Research Programme (grant number NIHR200702) as part of the Partnership for REsponsive Policy Analysis and REsearch (PREPARE), a collaboration between the University of York and The King's Fund for fast-response analysis and research to inform the Department of Health and Social Care's policy development (www.york.ac.uk/prepare).

This report is based on independent analysis carried out by The King's Fund.

Views expressed and any errors are those of the authors only, and not those of the NIHR or the Department of Health and Social Care.

Our research and the recommendations drawn from it predate the government announcements made in March 2025 to significantly reduce running costs at the Department of Health and Social Care and NHS England and to abolish NHS England.

Contents

Summary

The Health and Care Act 2022 formalised integrated care systems (ICSs) as the level at which health and care partners come together at scale to set an area strategy for integrated care. Within ICSs, place-based partnerships bring together partners at a level that corresponds to communities to join up the planning and delivery of services, redesign care pathways, engage with local people, and address health inequalities and the social and economic determinants of health. The Act and subsequent guidance have allowed for local flexibility in how place-based partnerships work towards these aims.

To date, there is little information available nationally about place-based partnerships: how they are set up, what they do, what resources they have, and what factors facilitate or impede their progress. We researched these through a survey with place-based partnership leaders, and three case studies.

We found that place-based partnerships were focused on critical local issues (such as hospital discharge and waiting times), and there was also a strong appetite for tackling health inequalities by focusing on their root causes. But progress was often hampered by the governance models, and decision-making was not always clear to all members of the partnerships. Health and care partners described themselves as being accountable to their own organisations, and there were no mechanisms for them to hold each other to account for work that would benefit places as opposed to individual organisations.

Our case study sites were facing extremely challenging financial circumstances and there was wide variation in how much integrated care boards (ICBs) had delegated budgets, with one even taking back delegated funds. In addition, the approach to pooling budgets in some places was still in development and had not become embedded as a default way of working.

Partners acknowledged the importance of strong relationships. However, there were differences in ways of working, and perceived power imbalances within place-based partnerships that frustrated efforts to work collaboratively. In some

places, there appeared to be misalignment in the aims and approaches taken by ICBs and by place-based partnerships.

Our findings suggest there is an urgent need to clarify and reinforce what role place-based partnerships should play in ICSs in transforming local health and care services, and how they relate to ICBs, particularly in light of recently announced plans for introducing neighbourhood health services, separating strategic commissioning from performance management, and reforming local government.

Based on our findings, there are three key areas that will support place-based partnerships to work effectively: accountability, collaborative leadership and resources. For these, it is recommended that:

- guidance and resources are developed on stronger governance and mutual accountability at place level
- place-based partnerships should invest time and effort into developing their practice of collaborative leadership, and national frameworks and guidance should reinforce expected behaviours and ways of working
- national guidance should set expectations of the markers of maturity that place-based partnerships should meet and tie those to greater delegation of budgets. Sharing examples of good practice in pooling resources (eg, addressing the technical barriers) should also build confidence among the organisations involved in place-based partnerships.

1 Introduction

Place-based partnership working has existed in various forms for decades and is based on an extensive body of literature that points to the importance of places and communities in shaping people's health and wellbeing (Buck *et al* 2018). Place-based working seeks to bring stakeholders together to use common resources to plan and arrange services for populations according to needs and other local factors (Charles *et al* 2021; Ham and Alderwick 2015).

In the English health and care system, successive policies have sought to integrate health and care services locally (National Audit Office 2017). Most recently, the Health and Care Act (2022) created integrated care systems (ICSs), which bring together health and care organisations for relatively large populations (average 1.5 million people). Within ICSs, there are integrated care partnerships (ICPs), which define their strategy, and integrated care boards (ICBs), which are statutory NHS organisations tasked with the planning, financial management and oversight of health services (NHS England 2022). In 2022, the White Paper *Joining up care for people, places and populations* identified 'place' as the key level at which integration of health and care services happens. It outlined a roadmap for developing place-based partnerships, including shared outcomes and the pooling of NHS and social care budgets at place level (Department of Health and Social Care 2022).

'Place' in this sense refers to a level within ICSs that typically covers populations of between 250,000 and 500,000 people. Place-based partnerships are non-statutory collaborative arrangements between NHS, local government and other organisations responsible for arranging and delivering health and care services, and others with a role in improving health and wellbeing. In our research, we have used this NHS definition of 'place'.

A hallmark of place-based partnerships is the concept of subsidiarity, whereby decision-making about health and care arrangements happens at the level closest to the populations and services impacted by those decisions (unless there are clear benefits from taking a decision at greater scale). This theme reiterates the need for local communities and the professionals working with them to have control

over priorities, decision-making and future planning, as they are best suited to understand and develop their local priority needs, while ICSs focus on functions at scale (Naylor and Charles 2022).

The diagram below illustrates the key functions of place-based partnerships. A recent literature review suggests that several factors are key to effective commissioning for integrated service delivery at place level. These include strong leadership and management, good relationships, inter-organisational governance structures that support collaboration, appropriate financial mechanisms and funding levels, and workforce support (Checkland *et al* 2024).

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 co-ordinating services around people's needs

3. Jointly planning and co-ordinating 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

Source: Charles *et al* 2021, p 22

About this research

In 2023, the Department of Health and Social Care (DHSC) approached The King's Fund wanting to know what progress has been made by systems in arrangements for place-based partnerships, and what impact those arrangements have had, to inform its future planning and support to place-based partnerships. Particular areas of interest included:

- the development and use of shared outcomes by place-based partnerships
- the governance models adopted by place-based partnerships
- the impact of delegation to place-based partnerships from ICBs, including the shifting of resources
- the use of pooled and aligned budgets between the NHS and local government
- integration across service areas within a system
- the barriers and facilitators to integrated working at place level.

The King's Fund designed the research around three questions relating to:

- the profile of place-based partnerships across the country, in terms of arrangements or mechanisms for leadership, governance and accountability, and delegated functions/budgets
- the nature of partnership working at place level in support of driving and sustaining integration
- any challenges or barriers experienced by partners and the potential policy solutions for those.

Due to its breadth, the research was divided into two phases. Phase 1, in 2023, used scoping interviews with a small number of place-based partnership leaders to gain preliminary insights and test the feasibility of running a nationwide survey.

For phase 2, in May and June 2024, a survey was sent to 121 place-based partnership leaders (or their proxies such as ICB communications or research and development (R&D) departments) across England. There were 78 survey responses, of which 48 could be fully analysed, providing broad descriptive information on governance, leadership, and delegation of functions and budgets.

From these responses, we selected three case study sites for further research based on current state of delegated budgets (whether fully, partially or not delegated). These case study sites reflected a broad range of demographic characteristics. During the case study research (September to October 2024), we conducted 28 interviews across the three sites with various stakeholders in the place-based partnership, including the lead, chair, ICB and local authority representatives, local NHS providers, GPs, Healthwatch, and voluntary, community and social enterprise (VCSE) representatives, to gain a holistic perspective of partners' views. Topics included their role in the place-based partnership, governance and accountability mechanisms, finances, and partnership working.

Research participants consented to interviews being recorded. Interviews were transcribed and analysed thematically using MAXQDA software. To preserve the anonymity of the place-based partnerships and research participants (who have ongoing working relationships), we refer to them as sites A, B or C.

About this report

This report sets out the background to place-based partnerships (in terms of the vision and expectations) and the policy context in which they are currently operating and a summary of survey findings (with a more detailed write-up in the appendix).

After a 'snapshot' profile of the three case study place-based partnerships, we set out findings from our interviews, including:

- how place-based partnerships are set up (in terms of structures, and governance and accountability arrangements)
- what place-based partnerships are doing (their priorities, strategic direction and examples of impact)
- the financial resources that place-based partnerships need to fulfil their aims and ambitions
- the nature of relationships and partnership working.

Finally, we discuss the implications of our research findings and considerations for policy, guidance and future support for place-based partnerships. (These predate the government's announcement to abolish NHS England.)

2 Background and policy context

How place-based partnerships have developed

Although place-level partnerships have existed for many years (including before the formalisation of ICSs), the policy momentum for place-based partnerships as they are seen today has been building since the Health and Care Act 2022. The 2022 White Paper on health and social care integration set out the vision for places as 'the engine for delivery and reform' and introduced expectations for a 'single person of accountability' with responsibility for delivering shared outcomes and 'strong, effective leadership' at place level (Department of Health and Social Care 2022).

The NHS and the Local Government Association jointly published a guidance document on the development of place-based partnerships, *Thriving places*, which strongly encouraged all partner organisations within ICSs to 'collectively define their place-based partnership working', including priorities and mechanisms for governance, decision-making and accountability (NHS England and Local Government Association 2021). *Thriving places* set out recommendations on membership, governance and accountability for place-based partnerships. The guidance regarding membership reiterates the importance of an inclusive partnership, naming various local stakeholders that should be included (such as primary care, health and social care providers, the VCSE sector, service users and ICB representation). Various governance models were outlined, which could be developed depending on places' distinct characteristics. The DHSC published a toolkit to support place-based partnerships in developing shared outcomes, including suggested models of delivery (Department of Health and Social Care 2023a).

In 2023, the Hewitt review assessed the facilitators and barriers to the success of ICSs (Department of Health and Social Care 2023b). It emphasised the importance of ICBs empowering place-based partnerships to drive local initiatives and define their own priorities as systems mature.

More recently, the Labour government has developed a health mission based on three key shifts required to accommodate the evolving needs of the population, and is preparing a 10 Year Health Plan to implement it (Streeting 2024). The strategic shifts are: from sickness to prevention, from hospital to community, and from analogue to digital. Places, and particularly neighbourhoods (with populations of 30,000–50,000 people), have become more prominent in recent policy; NHS England has issued guidelines for 'neighbourhood health' to pave the way for the 10-year plan. Essentially, place-based partnerships (along with ICBs) will be at the forefront of establishing neighbourhood health by strengthening primary and community-based care and connecting people accessing health and care to wider public services and support from the VCSE sector (NHS England 2025a).

A challenging and changing context for place-based partnerships

There are high expectations that place-based partnerships can transform health and care. However, it is important to understand the very challenging environment in which they are working. Demand for health and care is at an all-time high, which means that improving access and significantly reducing waiting times are also key priorities for the government (Department of Health and Social Care and NHS England 2025).

At the same time, the NHS and local authorities (as commissioners of adult social care) are under pressure to achieve financial balance. Measures to improve NHS finances include enhancing productivity, and a 30% real reduction in running costs per ICB between 2022/23 and 2025/26 (NHS England 2023) – and, given the overall financial deficit in the NHS, the interim Chief Executive Officer of NHS England has recently asked ICBs to halve their running costs by October 2025. Research by the NHS Confederation highlights the impact of running cost allowance (RCA) reductions, with financial challenges (among other factors) 'holding back' place-based partnerships from delivering their intended functions (Perrin *et al* 2024). The same research also highlights how the focus on tackling financial challenges in the NHS has led to 'command and control behaviours' showing up in the health care system, and a 'lack of system or partnership maturity' is a barrier to place-based partnerships being able to accelerate their work on integrating health and care services (Perrin *et al* 2024, p 4). Other research shows that different working cultures, power imbalances, and a lack of accountability within multi-agency partnerships can be barriers to working effectively (Hoole 2024).

Alongside the health mission and three key shifts, the Labour government is proposing to dramatically expand the devolution of decision-making and funding (to regional mayors) and to reorganise local governments 'for two-tier areas and for those unitary councils where there is evidence of failure or where their size or boundaries may be hindering their ability to deliver sustainable and high-quality services for their residents' (Ministry of Housing, Communities and Local Government 2024). The proposals could represent opportunities for place-based partnerships: for instance, in unitary authorities with populations of around 500,000 people, the reorganisation could help to tackle health inequalities. However, research shows that there are significant barriers to fulfilling the ambitions of devolution and place-based partnership working, including the UK's 'highly centralised system of governance, complex sub-national governance architecture and unstable funding arrangement' (Hoole 2024).

Thus, the challenging and changing backdrop for place-based partnerships should be borne in mind as we outline the findings of our research.

3 Summary of survey findings

In this section, we have summarised headline findings from our survey of place-based partnerships – specifically focusing on arrangements for leadership, governance and accountability, working relationships, perceived progress, and the delegation of functions and/or budgets.

The survey required building an email distribution list for all place-based partnership leaders in England. Desk research by the DHSC uncovered names for 51 leaders of 180 place-based partnerships (around 28%). We built on the desk research and found 121 email addresses for the leaders or their proxies, which we acknowledge is not the complete number of place-based partnerships in England. Tracking down names and email addresses was challenging as this information was not always in the public domain and, when we were able to get through to ICBs, they did not always readily release the information we requested.

The survey was administered between May and June 2024, and we received 78 responses. Of those, we analysed the 48 responses that were more complete and not duplicate entries (ie, analysis is based on one survey response per place-based partnership). More details about the survey can be found in the appendix.

Leadership and accountability arrangements

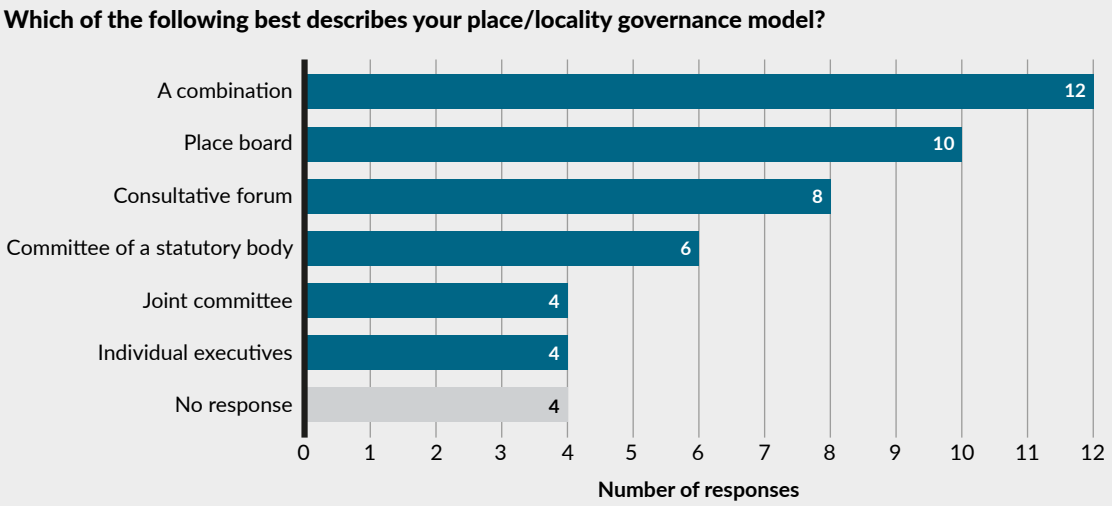
The survey asked about the individuals leading or directing place-based partnerships. Most leaders of place-based partnerships in our survey sample were NHS employees; 23 leaders reported that they were employed by an ICB and 10 by an NHS trust. Nine leaders reported that they were jointly employed by the NHS and a local authority, and a small number (four) were solely employed by a local authority.

Twenty-three respondents reported that there was a single person of accountability (SPoA) for their place-based partnership. As with leaders of place-based partnerships, SPoAs tended to be NHS employees. Twenty-five respondents said there was no SPoA in their partnership.

Governance arrangements

The survey asked respondents which of the governance models outlined in *Thriving places* best described the one for their place-based partnership, and there was an option to note whether the model was a combination of models (*see* Figure 1 and Box 1 for definitions). The variation suggests that place-based partnerships have formed in different ways. The findings from our case studies (in later sections of this report) provide further insight into how different partners experience the governance of place-based partnerships.

Figure 1 Governance model of place-based partnerships



Source: Survey by The King's Fund. Survey in the field May–June 2024

Box 1: Suggested governance models for place-based partnerships

Consultative forum: A collaborative forum to inform and align decisions by relevant statutory bodies, such as the ICB or local authorities, in an advisory role. In this arrangement, the decisions of statutory bodies should be informed by the consultative forum.

Individual executives or staff: Statutory bodies may agree to delegate functions to individual members of staff to exercise delegated functions, and they may convene a committee to support them, with membership that includes representatives from other organisations.

continued on next page

Box 1: Suggested governance models for place-based partnerships *continued*

Committee of a statutory body: A committee provided with delegated authority to make decisions about the use of resources. The terms of reference and scope are set by the statutory body and agreed to by the committee members. A delegated budget can be set to describe the level of resources available to cover the remit of the committee.

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

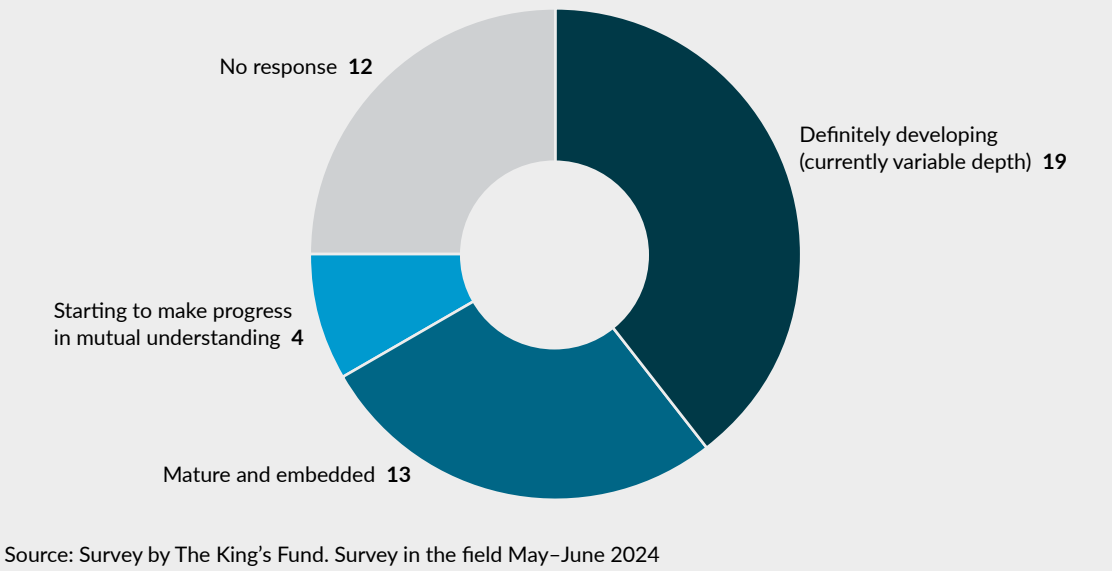
Place board: An arrangement bringing together partner organisations to pool resources, make decisions and plan jointly with a single person accountable for the delivery of shared outcomes and plans, working with local providers (ie, the single person of accountability).

Source: Department of Health and Social Care 2022; NHS England and Local Government Association 2021, pp 24–26

Working relationships

The survey asked place-based partnership leaders to describe the nature of working relationships on a scale indicating the level of maturity. For this question, 19 selected the description of 'definitely developing, currently variable depth' (*see* Figure 2, p 16). The main barriers to effective partnership working were cited as financial challenges in the NHS and local authorities, with only a few respondents citing challenges such as a lack of understanding about different roles/responsibilities (n=5) or resistance to change (n=2). Relationships and partnership working was a very strong and recurring theme in our case study interviews, which we discuss more fully in Section 8.

Figure 2 Perceptions about the nature of working relationships



Source: Survey by The King's Fund. Survey in the field May–June 2024

Perceived progress

The survey findings suggest that leaders of place-based partnerships are generally positive about making progress towards fulfilling the ambitions set out in *Thriving places*. There was a good level of agreement (ie, either 'strongly agree' or 'agree' responses) that place-based partnerships:

- have a shared vision
- are making good progress on plans to join up services to meet the needs of local people
- are using population health data in order to inform service transformation
- are working well with the VCSE sector to improve health and wellbeing for the local population
- are making progress to tackle the wider determinants of health.

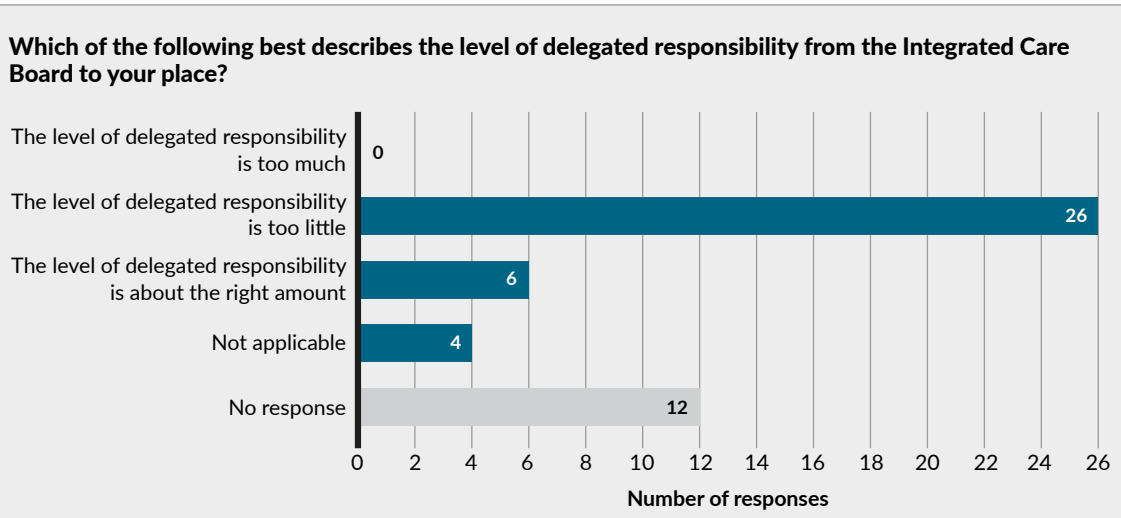
There was less sense of progress being made against other goals from *Thriving places*, such as:

- more collaborative commissioning of NHS and local authority services
- the integration of health and care services being informed by the people who use those services
- alignment and sharing of management or operational resources.

Delegated responsibilities and budgets

In the survey, the most common response was that too little responsibility had been delegated to place level from the ICB (*see* Figure 3). For a separate but similar question, 27 place-based partnership leaders reported that they either strongly disagreed or disagreed with the statement 'the allocation of decision-making and responsibility to place-based partnerships is appropriate', compared with six who either strongly agreed or agreed with the statement, and another six who were ambivalent (*see* Figure A4 in the appendix). This suggests there is considerable dissatisfaction among place-based partnership leaders about the level of delegated responsibility.

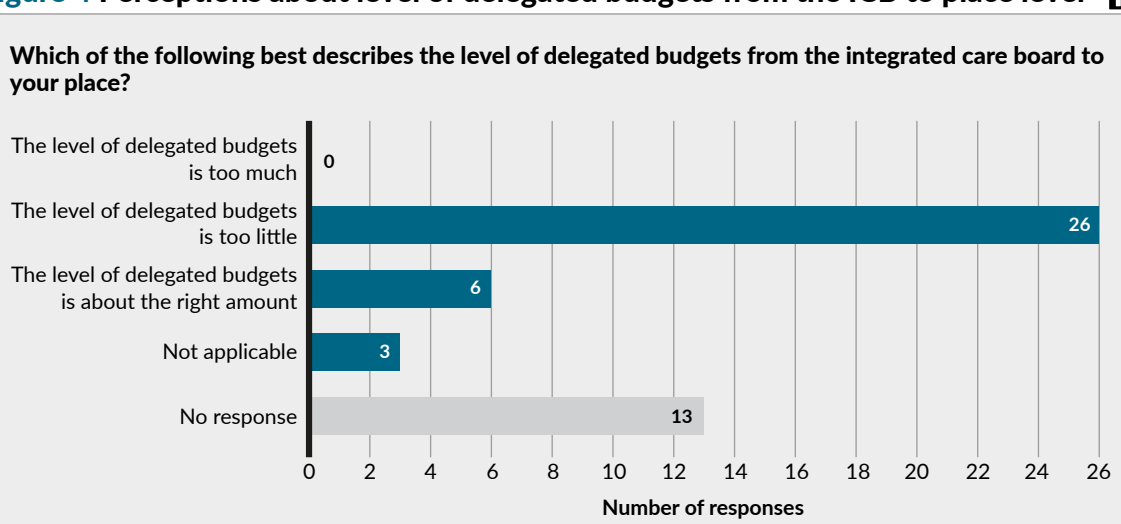
Figure 3 Perceptions about level of delegated responsibility from the ICB to place level



Source: Survey by The King's Fund. Survey in the field May–June 2024

The survey also asked whether budgets had been delegated from ICB to place level. Only two respondents reported full delegation of budgets to place level, with a further 13 reporting partially delegated budgets already, and six respondents reporting that there were plans for delegated budgets within the next 12 months. Eleven respondents said there was no delegation of budgets and four reported no current plans to delegate budgets. As with perceptions about the level of delegated responsibility, most respondents reported that the level of delegated budgets was too little (26), although six felt it was the right amount (*see* Figure 4).

Figure 4 Perceptions about level of delegated budgets from the ICB to place level



Source: Survey by The King's Fund. Survey in the field May–June 2024

For our case studies, we selected one place-based partnership with fully delegated budgets, one with partially delegated budgets, and one where there were no current plans to delegate budgets. Profiles of the three place-based partnerships are provided in the next section and further insights about the delegation of budgets (or lack thereof) are set out in Section 7, 'Resources'.

4 Case study profiles

In this section, we present brief profiles of each case study site to contextualise the findings of our research, which are set out in the subsequent sections. We have deliberately masked some features that would make sites identifiable. We can say that, across the three sites, there were some important contextual issues to note, as follows:

- In one site, there were concerns that the ICB would remove the place-based partnership lead role as part of their RCA reduction measures.
- In two sites, the ICB was categorised as being in the fourth 'segment' of the NHS Oversight Framework, placing them among some of the most financially challenged systems and requiring intensive support.

Site A

This urban site has a large population and is coterminous with a metropolitan district council.

- The governance model is a joint committee.
- It has a single person of accountability (SPoA) as well as a shared outcomes framework.
- It has fully delegated budgets.
- Since the creation of ICSs as statutory bodies in July 2022, there has been increased pooling of budgets under Section 75 arrangements at place level, with plans to pool more in the future.
- Working relationships were described by the place-based partnership leader as 'definitely developing (currently variable depth)'.

Site B

- This mixed urban–rural site has a large population and is coterminous with a county council.
- The governance model is a consultative forum.
- It does not have an SPoA and has developed a shared outcomes framework.
- It has partially delegated budgets.
- Since the creation of ICSs as statutory bodies in July 2022, there have been no changes in pooling of budgets under Section 75 arrangements at place level, but there are plans to pool more in the future.
- Working relationships were described by the place-based partnership leader as 'definitely developing (currently variable depth)'.

Site C

- This mixed urban–rural site includes coastal areas, has a medium-sized population, and goes across two upper-tier local authorities.
- The governance model is a joint committee.
- It has an SPoA and has not developed a shared outcomes framework.
- It has no delegated budgets.
- Since the creation of ICSs as statutory bodies in July 2022, there has been decreased pooling of budgets under Section 75 arrangements at place level.
- Working relationships were described by the place-based partnership leader as 'definitely developing (currently variable depth)'.

5 How are place-based partnerships set up?

In this section, we outline how the interviewees in the three case study place-based partnerships described their respective governance arrangements and their roles within the partnerships. We discuss how structural factors (particularly governance and accountability arrangements) act as either barriers or enablers to collaborating effectively. Finally, we focus on the relationships between the place-based partnerships and other parts of their local systems.

Governance and accountability arrangements

Across all three case studies, there was some history of most partners working together formally or informally before place-based partnerships (or health and care partnerships, as they were commonly referred to) were formed. The most formal previous arrangement was in site A, where several (but not all) partners had been brought together in an accountable care partnership, which then 'evolved' into the place-based partnership in its current form. Thus, there was already a degree of experience of collaboration among site A partner organisations.

In Table 1 (p 22), we have set out high-level descriptions of the current governance arrangements in the three case study place-based partnerships, based on their survey responses and interviews. Chairs of the place-based partnerships were from the acute care trust and the county council.

Table 1 High-level description of governance arrangements in the case study place-based partnerships

	Site A	Site B	Site C
Governance model	Joint committee	Consultative forum	Joint committee
Leader	An executive of the ICB with delegated authority and budget for the place-based partnership. The leader is also the SPoA and the representative of the ICB at place level.	Employed by the ICB with partially delegated authority and budget for the place-based partnership. The leader is not the SPoA.	Role is funded by the ICB and hosted by an independent sector provider, with no delegated authority and budget for place. The leader is not the SPoA.
Shared outcomes framework for place	Yes	Yes	No
Partnership board	Yes	Yes	Yes
Member partners	Primary care, acute health care providers, community health care provider, local authority (Chief Executive Officer (CEO), Directors of: Public Health, Adult Social Care, Children's Services and Finance plus elected members, and health and wellbeing board chair), Healthwatch, social care provider, VCSE organisation.	ICB representative (executive level), primary care, acute health care providers, community health care provider, local authority (Directors of Public Health and Adult and Children's Services, representative of city and district councils), Healthwatch, social care provider, VCSE organisation.	ICB representative (executive level), primary care, acute health care providers, community health care providers, local authority (Director of Public Health), Healthwatch, social care provider, VCSE organisation, housing providers.
Committees/ sub-groups or meetings	A Section 75 Committee that oversees the Better Care Fund. Board meetings for the partnership include 'development days' in which partners take a deep dive into different priority areas. There is a delivery group for primary and community care.	A joint executive committee that oversees and makes decisions about pooled resource, and delivery group meetings chaired by the chief operating officer from the acute care trust.	Various sub-groups including a strategic development group and 'task and finish' groups, and an informal meeting of local system leaders (the ICB, NHS and independent provider CEOs, Director of Adult Social Care and another local authority representative) that takes place fortnightly.

We asked interviewees about the 'nuts and bolts' of governance arrangements in their place-based partnership. Place board meetings occurred roughly monthly or quarterly across the three case studies, in some cases with an opportunity for informal networking afterwards.

Partners described spending anywhere between a few hours per quarter or the majority of their working week on place-based activities (either at board or sub-committee meetings or on delivery) depending on their roles – and on their level of engagement or appetite for the governance of place-based partnerships. For instance, in one site, the Director of Public Health said they did not want to get involved in governance and that, 'It's not my job to sort all of that out.' In contrast, the Director of Public Health in another site thought the amount of time spent on place-based working (including governance meetings) was beneficial to their core role:

> *My job is to make everything complementary, so the work I'm doing on health visiting with our children's team complements the place-based partnership.*

As Table 1 shows, membership of place-based partnerships was reasonably broad and comprehensive in each case study site.

We note that across the three sites, representatives from the VCSE sector and Healthwatch described being formally involved in place-level strategy as a result of place-based partnerships coming into existence – and they welcomed this development.

> *So we were… invited into that process from the start and then [we were] there as, like, a permanent member. And it's been really good to have that seat at the table for that.*

Interviewees were asked about how accountability arrangements within place-based partnerships worked. Mostly this was described as different partners reporting activity and outcomes to the place-based partnership's sub-committees, and place-based partnerships reporting to their respective ICBs. In addition, there were multiple chains of accountability within place-based partnerships – ie, NHS care providers being accountable to ICBs, and local authorities (which could be more than one at place level) being accountable to the public and the elected members who represent them.

Barriers and enablers

Overall, the various members of place-based partnerships were positive about their role and input. Most often, they described their roles as bringing their expertise (eg, GPs providing a clinical perspective) and, equally as important, their connections and contacts (eg, other local VCSE organisations). Interviewees were also positive about the information and connections they gained through their membership, as well as input into relevant strategic discussions.

None of the interviewees described there being an ideal model for governing place-based partnerships, but they were getting on with working in the structures they had. However, with the exception of the three directors of the case study place-based partnerships, other partners seemed less clear about how and where decisions are made, and the extent to which they could influence decisions.

> *…the governance has sort of evolved a bit loosely and including in the ICS itself, so it's not entirely clear where some of these decisions are being made by… you know, when you've got individual providers having to collaborate together.*

> *…well, the money has to figure in this somewhere, and those money decisions are not, I have not made a single decision, or been part of a single decision, really, that's been made in the last four years… because the decision's already made somewhere else. I'm on the receipt of decisions.*

We heard examples of tensions between individual organisational interests and priorities and those of the wider partnership – for example, in one case study site where a procurement exercise was under way for a single contractor for community care services and several partners were in line to bid for it. This was described as taking up several partners' bandwidth and diverting focus from other topics of discussion.

We also heard concerns from a small number of interviewees in two of the case study place-based partnerships about the perceived bias of the partnership chair – ie, the chairs were seen as focusing disproportionately on the priorities of their own organisation, which affected some partners' ability and willingness to work together. For example, in one place-based partnership where the chair was from the local authority, one partner felt that meant that discussions about resource allocation

favoured joint NHS–local authority initiatives focused on hospital discharge, excluding other partners who could play a role in preventing hospital admissions and caring for people in community settings. We note, however, that in the interview with the chair in question, they spoke about having 'pushed equally' in the interests of (NHS) patients and (local authority) citizens.

Although partners were brought together in formal structures to govern place, there was a tendency for partners to default to their organisational priorities. This was largely due to partners continuing to work within existing accountability structures in the NHS and local authorities.

> *We're all accountable to our boards or our governance structures. For the [place-based partnership] we're not really accountable to it because the accountability rests at the [ICB area] level with the ICB. And that's definitely a thing and I think it's affected the solidity of the relationships and the, sort of, 'who's answerable to who' question. It's probably worth me saying that ICBs, and as a result HCPs [health and care partnerships], they're a function of the NHS… Local authorities are not really culturally part of this. And DHSC [Department of Health and Social Care] will give a broad operating mandate to NHS England; NHS England will bark instructions at the ICB; the ICB will say 'yes ma'am, how high would you like me to jump?' And that then gets transmuted down to the [place-based partnership]. And foundation trusts are accountable to ICB, NHS England and the CQC's [Care Quality Commission] health care regulator. Local authorities aren't really part of that in governance terms… Short of recreating whatever the next version of ICBs is with statutory accountability to place and strong roots in place and some form of democratic accountability, I don't know what would make it better… Therefore, by default, we'll just muddle on. And it doesn't feel terribly satisfactory from any perspective at the moment.*

The topic of accountability often exposed partners' frustrations about challenges with holding each other accountable at place level. That is not to say that partners entirely avoided having challenging discussions with each other, but there was no formal mechanism for mutual accountability. The leader of one of the place-based partnerships outlined the challenging nature of trying to collaborate without the ability to keep partners to task on work that could benefit place:

> *…we've had multiple… occasions where we'll all sit in the room and we will make a decision and everybody will make the decision and we'll all agree, and then people*

leave the room and it's like that conversation never actually happened, you know? Even though those conversations are minuted… I mean, a prime example is over the piece of work we're doing on transforming flow and discharge, so it's our… Transfer of Care Hub model at the moment. Now we brought in two different auditors last year to look at the system, to look at what we needed to do… They told us, two of the organisational partners didn't like the answer, so we brought in a third [auditor], so this is a lot of money that you're spending, and the third organisation that came in said exactly the same thing, you know, you need to do this if you're going to fix this… So, we then all agreed that this is what we were going to do, and my team start to deliver it and then the acute trust said, 'no, we don't want to do that'. So, they then walk away from the table. So, we've now brought in a fourth individual who's telling us exactly the same thing, and this piece of work could have been done a year ago, and should have been done a year ago, and it's that frustration that is problematic.

Relationships with other local health and care bodies

The local landscape that place-based partnerships overlapped with or were connected to was generally described as a 'complex and complicated' arrangement. We heard how partners were often either members of, or had some crossover roles with, other bodies working across place footprints, most notably health and wellbeing boards, but this could also be primary care networks, 'acute federations', mental health alliances and VCSE alliances. As one partner remarked: 'You could spend your life in partnership meetings.' Partners noted that being part of multiple bodies was time intensive. As one partner observed, working across different partnerships meant they had to be 'intentional' about how to use their time, and encourage colleagues within their organisations to do the same.

We also heard about the challenges of multiple membership. For example, in one site, we heard how the multitude of primary care bodies created some difficulty in working efficiently:

[Place name] is not unique, [in] that we've got a complicated arrangement architecture, if you like, for primary care. So, give or take one or two, we have [more than 70] general practices in the city. We have 15 primary care networks. We have the local medical committee… which is advocating for some of the terms and conditions and contractual arrangements for individual practices. We also

have an organisation called Primary Care [place name] and it would be lovely if all of those different groups all saw things in exactly the same way, but of course they don't. So how you bring primary care into some of these conversations in a straightforward way is tricky.

In another site, we heard how the complexity of arrangements could lead to a lack of clarity about the responsibility at place level for health, with specific reference to the health and wellbeing board:

[The relationship between] the health and wellbeing board and health [and] care partnership is interesting. The health and wellbeing board in [place name] has made a very deliberate choice to focus more on the wellbeing part of health and wellbeing, and less on certainly the health care bits of health. So that's… a very deliberate choice. That raises some interesting dynamics and some interesting challenges… So, is that relationship entirely clear? No, but… it's a smallish city, you've got similar people sitting in both places. But where does the Better Care Fund go for sign-off, for instance? I think it is formally signed off, approved and ratified at the health and wellbeing board. I think that's a statutory requirement. It comes through the health and care partnership, which has got the trusts included on it as well. So, there are some of those formal links that come through there.

We also heard that multi-layered landscapes could, in theory, create confusion about where responsibility and accountability sit for various things. However, partners in place-based partnerships were fairly confident that such issues would be ironed out given time – as long as place-based partnerships remained alert to them and responded appropriately:

I think we just need to ensure that we're doing the right things at the right level and that we're not confusing or conflating anything, but we've got a governance process that is agile and flexible and doesn't stop us doing things. And also the NHS can't act alone. So actually the real value of health care partnership is that it's not about the NHS, it's about the partnership, the place, and we draw in lots of expertise around that, which I think is hugely helpful and beneficial.

Place-based partnerships and neighbourhood-level working

Partners in the three case study sites described being at the early stages of establishing integrated neighbourhood teams (INTs). In site B, which was relatively further ahead than the other two, we heard there were three 'pretty mature' INTs with funding and priorities agreed, and another three that were still emergent. In site A, the clinical directors on the place-based partnership had agreed the geographical populations to be covered by neighbourhood teams, but, overall, INT working was still in the 'planning stage'. Finally, in site C, INTs were still a 'concept' as opposed to a reality, and one partner felt that the ICB taking a centralised approach to establishing INTs would not necessarily reflect or meet needs at the granular level of neighbourhoods.

Impact of local authority boundaries

Two place-based partnerships were coterminous with the (upper-tier) city or county council. In those sites, interviewees did not mention any particular impact of local authority boundaries on place-level working.

In one place-based partnership, there was an overlap with multiple upper- and lower-tier local authorities. Having several local authority boundaries across the place-based partnership presented some difficulty in working across them all. For example, we heard how the VCSE sector had to work across the multiple boundaries and try to 'join up services that cross each of the district councils'.

We also heard how the different levels of pooling of budgets across councils created a challenge for the place-based partnership where there were different levels of engagement and participation from social care services across the place footprint. We heard how one (unitary authority) council within the place had more 'prevailing powers' over the wider determinants of health (ie, housing, economic regeneration, employment and education), leading to different levels of autonomy to agree to changes impacting the wider determinants.

Finally, we heard about the difficulties created regarding patient flow as a result of a multitude of local council involvement in discharge design. As one participant told us:

> *The [boundaries of multiple councils], massively [impact the work of the place-based partnership], because the local authority boundaries don't really match patient*

flow… They [the councils] all have different assessment models, they have different ways of – what do they call it in local authority land, 'means testing of individuals', and they have different criteria for what they will and won't take… So that, it really does impact on how the partnership sees its model that it described for discharge, for example, so there is no or very limited consensus around that. They say, yes, we will discharge patients… that's agreed as the health and care partnership… But then it comes to the mechanics of that and that's where it falls down, because you're subjected to… at least three different ways of doing something… So we find ourselves in a very difficult position.

6 What are place-based partnerships doing?

In this section, we discuss the priorities in the three place-based partnerships and what they were doing to address those.

Priorities

Although each site had unique sets of needs within their local populations, there was a strong theme and focus across all sites on tackling inequalities.

> *We've decided upon seven priority areas now where we think we can make a difference. Managing inequalities is a theme that I think is an underpinning thing. I think we recognise that in [site A] we've got significant inequality between our richest and our poorest communities, significant life expectancy and years lived in ill health gaps. So that underpins what we do. And then we've got some very specific challenges.*

We heard about the following specific issues or challenges across the three place-based partnerships:

- tackling long waiting lists/times
- patient flow and discharge
- hospital admissions for cardiovascular disease (CVD)
- hospital admissions linked to substance misuse and mental health crises
- hospital admissions for childhood asthma (and other respiratory conditions)
- neurodiversity (particularly for children and young people)
- mental health crises
- higher self-harm rates among young people
- obesity
- poorer cancer outcomes (compared to other places)
- medicines optimisation.

Partners in one site also mentioned that the local acute care trust had major issues regarding patient flow and discharge, coupled with a county council facing significant financial challenges.

We asked the interviewees to describe the priorities of their place-based partnership. Each of the sites has published strategies setting out the priorities and direction of travel for the place-based partnership. Although interviewees could describe the priorities of the place-based partnership in broad terms, most could not recall all the specific priorities agreed, with the exception of the place-based partnership leader. We found that other partners could talk more confidently about the priorities of their own organisations.

For example, in site A, the place-based partnership has been working on setting out the priorities over the past year. However, most participants were unable to definitively set them out. As one partner noted:

> *In terms of the specific priorities… we've all signed off on five of them, and now you're going to test me on what they are. The ones that, I suppose, matter… they all matter, but in particular our shared approach to discharge and how we're working on discharge given the pressure that puts on that system.*

The place-based partnership leader gave a more detailed explanation of the priorities. They told us that the priorities were co-produced and focused on where the partnership could add value, noting that:

> *Every organisation's got their own strategies, their own agenda, their own priorities, but actually where do we add value? So where does one or more of those partner organisations come together [in a place where] those wicked problems can only be solved by one or more or us?*

Some partners felt that priorities were still weighted towards specific parts of the place-based partnership, such as the acute sector or the NHS generally:

> *…it [the place-based partnership's priorities] seems to be so much of that is driven by the NHS in the end, despite the view that the whole ICB set-up was supposed to be more independent… It's less driven by links to the local government than I'd like it to be. And it's also driven by the needs of big services to be funded.*

In site C, there was a sense that priorities were drawn heavily from the ICB's priorities, which might mask needs at place or neighbourhood level. The lack of delegated budgets was also cause for concern for some participants as forming a particular barrier to achieving priorities agreed at place level:

> *We've got a delivery plan, yes, and again because… so we've got a strategy for the next… what we want to achieve in the next five years for the health and care partnership. Again, it will be easier if we ever get to the point of delegation. At the moment, we have no control over the budget that comes from the NHS and we have no control over… the priorities are dictated to us. So, we've tailored the ICB priorities to meet our… because not all the ICB priorities are relevant to my area, my patch.*

A common theme across the three place-based partnerships was the need to focus on prevention and reducing health inequalities. Some interviewees told us that place-based partnership is working well, with partners coming together to find ways to work together and develop new ways of working to join up care, improve population health and reduce inequalities. Partners felt that it was important to have the VCSE sector strongly represented on the place-based partnership as a way of accessing their networks and engaging local communities to reduce health inequalities, as the following quotes from two different interviewees illustrate.

> *The priority populations that we have chosen to focus on over the last two years are children and families with special educational needs and disability. We will move into more early years, 0–5 school readiness, [site B], particularly for children eligible for school meals, is worse than national average for school readiness and that is a real… as Michael Marmot tells us, that is a real determinant for life course. We focused on adult and older adult mental health. So bringing together social care, NHS providers and the voluntary and community sector into a single system and service.*

> *The neighbourhood development scheme is properly about community empowerment, delegation of funds, right to grassroots level. Get the community to identify their priorities, working with local community leaders. So that feels absolutely aligned to health inequalities, and it's focused in the north of the city where our most deprived neighbourhoods are. So, it's absolutely focused on health*

and inequalities and it's absolutely about driving broader socio-economic change and absolutely about population health. But taking a more community-based approach to that, which feels right.

Despite interviewees not always being able to recall all the priorities for their site, there was much hope about the importance of the strategic vision of the place-based partnership to make a difference in the long term:

It is within the strategy with priorities for health and care partnership. I think what health and care partnership does, it always does something that actually can carry on. I'll give you an example. So the health and care partnership did some work on asthma with children, and they engaged schools, they educated parents, they trained individuals within schools, so that is continuing. Now, that is making a difference now, but with the training programmes and education, it will continue into longer-term preventive services as well… The aim is still for all priorities, whatever we do, to have the impact or be self-sufficient in terms of generating impact into the future.

What is the value of place-level working?

When asked about the value of place-level working, participants noted a range of positive outcomes of working together, such as getting to the root causes of inequalities and transforming health and care.

Integration, transformation, and joining up care was seen as the real purpose of place, particularly with regards to the most disadvantaged communities. As one participant noted, working at place level is about identifying communities who are likely to benefit more from better joined-up care. And as they develop new models of integrated care, these will deliver better value for the system as a whole, by improving outcomes for those with the worst health outcomes, and using collective resources to focus on prevention.

I do think [place is] the right location for [transformation]. I think if social care, health care, voluntary sector colleagues, mental health, physical health colleagues, primary and secondary care colleagues are coming together in a forum in [a place-based partnership], it needs to be about transforming services for the future.

And as another participant noted:

> *We've tried a lot, as a health and care partnership, to bring people together from the different sectors and to do the planning in a much more integrated way. We've very much tried to be population health management-led in what we do.*

Interviewees in the case study sites placed great value on place-level working to tackle inequalities. In fact, some went as far as to contend that systems can only really reduce health inequalities if this is done at place and neighbourhood levels. They felt that place was the right level at which to make a material difference to people's lives and health:

> *I very much firmly believe that you need to do things at locality and place and down to sort of neighbourhood level, and unless you do that, you don't target inequality. It makes a difference to people, that's what place does… We do things at grassroot level… We make a difference to people… The real stuff that is making a difference to human beings and their lives and the lives of the people around them.*

Interviewees also talked about the purpose, value and opportunities for place-level working as being able to have an impact on population health and on health creation, away from a focus on the 'constitutional targets' such as waiting times, which can give place-based partnerships a sense of freedom and autonomy to 'do things differently', and be more creative:

> *…we've got a sum of money in place for the population, how do we best spend that money in an intelligent-led way that makes our population healthy and well and creates that…? We talk about health creation, what do we mean? But actually, if we just focus on the constitutional targets, we'll never change anything. But I think place allows us to get into those discussions, and also having elected members on the HCP [health and care partnership], which we do have, we have four now, gives [us more] local democratic legitimacy in terms of what we do at place, which I think [really] adds value.*

Examples of impact

The survey of place-based partnership leaders indicated progress in creating a shared vision, plans to join up services, using population health data to inform service transformation, working with the VCSE sector to improve health and wellbeing, and tackling the wider determinants of health.

We asked the case study place-based partnerships for more detail about what impact they have achieved for their populations. Examples are described briefly below.

Data and analytics in site A. The place-based partnership encountered information governance issues around the sharing of data and intelligence across partner organisations. It therefore established an analysis group to bring together analysts from partner organisations to undertake their own separate analysis of all available data on a given priority issue before feeding in to place-based partnership discussions. Some of this data was subsequently combined with health inequality data, making it possible to target activity at a postcode level. One deep dive into the issue of childhood asthma, for example, found that 16 children were responsible for 72 admissions. Support could then be offered to these families in a more directed and effective way. In another instance, the analysis group has been able to shed light on why there had been an unexpected increase in ambulatory care-sensitive conditions.

Devising community profiles in the 10 most deprived wards in site B to inform targeted action to tackle cardiovascular disease. This involved the analysis and sharing of public health data followed by a £500,000 investment in grants to community-based organisations to undertake further listening exercises with local communities to identify the initiatives that are most appropriate in each ward (which all have very different characteristics and obstacles to cardiovascular health). This approach was regarded as evidence of the value of having VCSE and Healthwatch partners around the table, as they co-ordinated and led the direct work with community-based organisations and citizens. It has also been used to make the case for a 'warranted variation' in approach to addressing health inequalities – because a standardised approach would not work so effectively in these 10 wards with very different types of need.

Social regeneration in site C. Through an engagement exercise with 2,000 people in the most marginalised communities, the place-based partnership established

evidence and a case for working together to address the wider determinants of health by adopting a different, more collaborative approach (ie, going beyond the 'classic' NHS role). Working with the VCSE sector, colleges, housing associations and primary care, partners are trying to 'join the dots' between the different domains of people's lives which affect their experiences of health and health care. One example was having conversations with housing associations about if and how their staff could support to make referrals for, or perhaps even undertake, frailty assessments with local residents who may be unlikely to present with health concerns to their GP. The goal, ultimately, is to prevent people's health from worsening, and to reduce hospital attendance and admissions.

7 Resources

In this section, we look at the financial resources the case study place-based partnerships had to achieve their plans and ambitions. This includes the level of budgets delegated from the ICB to place level: either full, partial or none. We also look at the extent to which place-based partnerships were able to utilise other resources, such as pooled budgets and other funding streams.

Delegation of budgets from the ICB

Site A: Fully delegated budgets

The ICB in site A has allocated around 38% of its budget to the place-based partnership. In terms of the structure to enable this, the place-based partnership exists as a sub-committee of the ICB, and the leader of the partnership (as an executive director of the ICB) has delegated powers to allocate financial resources through the partnership.

Just under 70% of the delegated budget is dedicated to 'big provider contracts' at place level, and the leader describes a sense of having 'a high level of autonomy, which a lot of places don't have'. Working with the leader of the place-based partnership is a group of senior leaders who make decisions about the allocation of some of the remaining 30% of the delegated budget.

> *We would look at [our priorities] as a partnership and say if we're going to make a difference to urgent [and] emergency care, my clinical lead is going round talking to everybody, talking to the medical directors about what is possible, then they would bring a business case into the partnership and we would debate that in terms of does it need to be a contract change, do we need additional resource, etc… I'd like to move as far as we can in that space with… [the] city council on how can we absolutely squeeze [value out of] every single pound that we worked together on.*

Another partner we interviewed (a director from one of the acute care providers) expressed support for having the budget at place level (as opposed to ICB level) in order to tackle 'local priorities'. This individual went on to share some concerns

about a lack of 'strong delivery plans… that will deliver on the finances'. Similarly, we note that the level of enthusiasm about the delegated budgets among other partners in site A was variable – particularly about how much money had truly been handed over to partners at place level. For example, one partner was not convinced there would be much funding made available for the partnership to use at its discretion once the allocation for health care providers had been accounted for:

> *Well, I'm fascinated that you say it's got a delegated budget. Yeah, well, interesting. I mean… it depends on what you mean by that, doesn't it? And it seems to be a lot of that budget goes straight to service providers… Two weeks ago, the chief exec of the ICB came to our health and wellbeing board. And one of the things he said was that we need to work harder at getting clarity about roles and powers and delegation right at the different levels. So that indicates to me that they actually don't think it is quite right. And he's very much got the line that ICBs are about subsidiarity, I don't quite believe that. I think they hold the reins more than they like to admit. But I think the reins are very much about acute hospitals and all that. So, I think the theory is great. I'm not convinced about practice.*

The leader of the partnership pointed out that although a significant amount of the budget was tied up in provider contracts, contract variations can be negotiated by the partnership.

Site B: Partially delegated budgets

The ICB in site B has allocated around 7% of its budget to the place-based partnership. This includes Better Care Fund (BCF), additional discharge, urgent and emergency care, and health inequalities funding. Committees have been established underneath the main board of the place-based partnership to decide and agree how the delegated budget will be used.

Along with the partially delegated budgets, the ICB representative on the place-based partnership had strongly encouraged partners at place level to view the funding as theirs to decide how to use:

> *We've also said to them, you know, the collective chief execs in the room, whether we have a contract with you or not, you control the money… We've given it to you, if you want to work with your neighbour trust about doing something different, just get on and do it. So we try to encourage that, and I think it's worked relatively well.*

Furthermore, the place-based partnership leader described with pride some examples of collaborative working that the funding had enabled – for example, a project to speed up hospital discharge. In addition, the leader has influenced the partnership to invest a significant proportion of delegated health inequalities funding in VCSE sector organisations that could work more flexibly and closely with people living in the most deprived areas in site B.

> *What we have done with our inequalities funding, again we agreed it early on and I was really intentional in this. I said, we have £1.5 million a year, I wanted to put most of it… I could have spent it in a day in general practice or in [an] acute trust, but I said I wanted it to go to voluntary community sector [organisations]. I think 93% of that funding went to [the] voluntary community sector. It is just the most awesome programme as a result of that because it is so different… We have got some deep inequalities that we are doing some really great stuff [on] with grassroots organisations.*

However, it is important to note that having partially delegated budgets does not mean that the ICB has merely handed over power and money to site B. As noted in Section 3, the governance model of the place-based partnership is a consultative forum, which means the ICB executive can overrule decisions made at place level. Moreover, one stakeholder was unsure whether further delegation was a good idea until relational issues had been addressed and finances teased apart.

Finally, due to the ICB being in significant financial deficit, it had effectively stopped all the place-based partnership's sub-committees from allocating funds to projects and activities at place level. Instead, funds were being pulled back to ICB level. The ICB representative shared their concerns about the impact this could have on future health and care needs:

> *But what worries me is that, and I'm about to write a letter to the [rest of the] ICB [executive], because they're under a massive financial deficit at the moment. And… their turnaround director is about to pull funding… to balance the books. And I know the inequality money is at risk… We're about to do the same mistake that we've done all the time, which is pulling the plug halfway through on these preventive initiatives. So, I'm about to write to them to ask them to protect that. Because we will see a difference, and that will ultimately save them money. And I think that's the thing they don't realise, the things that they're going to pull the plug on, are the things that will actually make them save money in the future.*

Site C: No current plans for delegated budgets

The overall budget for the ICB is just over £4 billion. At the time of our interviews, none of the four place-based partnerships within the system had been given delegated authority or budgets.

We were told by the place-based partnership leader and the lead for strategy that the direction of travel had been set for the delegation of authority and budgets to place level, including partners at place level drawing up a memorandum of understanding to underpin that. However, plans had been stalled for several months and, at the time of our interviews, there was no apparent timeline for when delegation would happen. In terms of why plans had stalled, some interviewees put this down to a change in personnel at executive level in the ICB, with two site C interviewees stating there was a significant difference in opinion about whether or not budgets should/could be delegated to place level (ie, certain newly appointed ICB executives were opposed to it happening). They said executives had been dismissive of attempts made by some of the place-level partners to reinstate plans for delegation and attend place board meetings to discuss the matter. This essentially meant there was an impasse regarding delegation. One partner described an apparent lack of willingness at ICB level to delegate budgets – to devolve that type of power – to place-based partnerships:

> *…what you've got in the health and care partnerships is people who know their place, as in the place… and then you've got another tier of commissioning at the ICB of people who are just looking at numbers, I think, and thinking at [a] very strategic level. It just doesn't feel like they are talking to each other enough to actually resolve this, and because there isn't a defined delegated budget, the staff members working at the health and care partnership, it just feels like they have their hands tied constantly.*

We interviewed a representative from the ICB who had previously worked with the place-based partnership to prepare for delegation until they moved into a different role at the ICB. They were aware of the frustrations of partners working at place level and offered a different perspective on the challenges to do with delegation on the ICB side. They said the ICB's financial recovery programme had diverted significant time, attention and resources away from delegation. Furthermore, there had been technical challenges in protecting the rights of commissioning staff when transferring them from the ICB to a non-NHS organisation that 'hosts' the

place-based partnership. They noted that other place-based partnerships in the system had made relatively more progress in assuring the ICB executive that they were in a good position to take on delegation, which was not deemed to be the case in site C:

> *So, in the two [place-based partnerships] that are progressing, they're hosted by acute trusts that are not in special measures, they are trusts which are quite stable… and I think that's allowed a bit of capacity to be able to progress… [T]he other health and care partnerships are led by the acute trust in the local area, and they have that reach and that presence, at say, the chief execs meetings of the NHS trusts together, it's enabled swifter progress on that, and I think the model of the [community provider in site C] leading it, has caused us some additional complications.*

It was certainly clear in our interviews that most of the partners working at place level in site C were very frustrated about the situation, feeling the ICB had gone back on its word and was effectively blocking the place-based partnership from fulfilling its potential to transform health and care for its population. In the absence of delegated budgets, the leader of the place-based partnership was proactively looking outside the NHS for funding:

> *The thing is I'm not very good when someone… puts an obstacle in my path [that will negatively impact on the population we serve], the nurse bit in me, the core value of what put me in the NHS… hits in. I mean, one of the things I'm working on at the moment is a big tech company have agreed to put in solar panels to the social housing houses in my patch for free, maintain them for 20 years, which means that those people can turn their heating on, which means that their respiratory conditions will lessen, they'll have less exacerbations. They're not going to be mentally stressed about whether they put food on the table or heating for their children. That, I can do at place, and that, I don't need the NHS for.*

Interviews in site C generally reflected a strong appetite for the place-based partnership to drive transformation, and to have the autonomy and budget to do that. However, the appetite for delegation was not universal across the partnership. For example, one partner (a director at the acute trust) pointed out that there is no 'consistent or holistic system plan' that all partners can hold to, and instead the partners each have their individual priorities and existing 'funding streams do all they need to do'.

Other funding sources

Across the three case study place-based partnerships, partners discussed using other funding sources such as additional discharge, winter planning, and health inequalities funding from NHS England. Those funding streams enable systems and place-based partnerships (where the money does flow through) to tackle local issues. However, partners described some challenges in bidding for ring-fenced pots of money that allow little flexibility to be creative or to tailor services according to different needs.

Partners in sites A and B talked about the BCF, with interviewees from each place-based partnership describing theirs as one of the biggest pooled budgets in the country. In site A, one partner (the Director of Public Health) said there has been a significant BCF for some time and the process of reporting about its use to the health and wellbeing board was 'a well-oiled machine'. However, another partner (from one of the acute trusts) felt the BCF was not living up to the ambition for full integration:

> *I think those budgets do sit alongside each other, they are looked at at the same time, but there are just fairly strict rules about how local authority budget can be controlled, managed and decided, and how NHS budgets can be controlled, managed and decided. That meant that the flow across that sort of line down the middle, the local authority side and the NHS side is negligible at the moment.*

The leader of the place-based partnership in site A acknowledged that open and frank discussions between partners were progressing at place level about where money can be diverted and efficiencies identified. Furthermore, as the Chief Executive Officer of the city council pointed out, although there is strong potential for greater pooling of budgets at place level, the reality is that there is a lack of money for everything that needs attention in health and care, and things like the BCF have strict rules and conditions attached.

Similarly, in site B, there is a structure in place for agreeing how the BCF should be spent (known locally as the 'joint commissioning executive', which the place-based partnership reports into). According to the representative from the ICB, the BCF has been formalised through a 'great big Section 75' agreement, which 'gives quite a strong baseline for partnership working, particularly between the NHS and the

local authority'. However, later in the interview, they acknowledged that it has been necessary for the ICB to step in and override decisions made at place level:

> *...so in our present environment of really constrained financial positions, we've had to go back into the BCF [Better Care Fund] and say, we want you to stop spending some money, please, because we can't afford it. And so, occasionally, you know, there's a bit of to and fro between local decisions and system decisions, and I think if I reflect on why that happens, I think it probably happens because, as an executive, which of course the place directors are not on, there's a tendency to look at the entire system all the time.*

Furthermore, one partner (the Chief Executive Officer of the community and mental health trust) said they felt that conversations among place-level partners tended to be dominated by those who wanted to use pooled budgets for urgent care responses, whereas others believed the funding should be invested in boosting capacity in district nursing, community nursing and primary care. This point speaks to some of the challenges in partnership working and relationships, which we outline in Section 8.

In site C, the Director of Public Health talked about a recent example of using the BCF (overseen by the local joint commissioning management group) to establish a nurse post for infection prevention in local care homes. However, the partner from the acute trust pointed out that there were challenges in pooling budgets at place level, possibly due to the multiple local authorities within the place-based partnership footprint and that the BCF itself amounted to 'tiny, tiny pots of money'. In addition, it was pointed out by the place-based partnership leader that the lack of oversight about each partner organisation's budget was a barrier to pooling budgets at place level – but something that partners were beginning to discuss openly, and directors of finance had committed to sharing data on budgets going forward.

We note that in site C, the place-based partnership leader talked about sharing resources, which helped strengthen working relationships between the NHS and VCSE sector:

> *We found new ways of doing things, so I haven't got loads of money, I work in the NHS, unfortunately it's not, you know, falling off the trees. But we have got assets, we have got resources, so I was able to offer community partners, voluntary partners, free training, for example. So I was able to say to them, do you know*

what, don't spend £500 a year when you're only a £10,000 charity on safeguarding training, we'll give it to you for free, which allows them to invest that £500. So, as soon as you start to do… I suppose it was almost like bartering, and then I was supporting them with bid writing, I was supporting with Lottery grants, and I was giving them data and things. And then they started sharing data with me, which we hadn't been in that position before, and we've now got a relationship where I can pretty much… if I need something to happen in the community, I can pick up the phone and they trust me. And I think that's the key.

Impact of reduction to the running cost allowance for ICBs

ICBs are operating in a very challenging financial environment, with the requirement to cut their running costs by 30% by 2025/26. We asked our interviewees about the impact of those reductions on place-level working. In site A, the leader of the place-based partnership said the push to reduce ICB costs had been a distraction and a worry while the partnership was discussing how to implement the delivery plan. Furthermore, site A – as the largest place-based partnership within the ICS – had the highest number of place-level posts reduced (ie, by 80%). One of the partners (from an acute trust) talked about the loss of 'a bit of the delivery power and momentum through the organisational change of the ICB'. The Chief Executive Officer of the city council wondered whether the reduced capacity at place level would potentially mean a 'single regional team' making decisions about where things are done – ie, at place or system level. The representative from Healthwatch was particularly disappointed about the loss of the dedicated communications and engagement team at place level, which had a knock-on effect on those who remained in the place-based partnership core team and affected the pace of local planning discussions and decisions.

And the other one I particularly picked up, it's a small thing but, each place-based team in [ICS name] had an engagement team to have actual staff. That's what they did. So, we mainly worked with them in [place name]. When the cuts came, they were all drawn in centrally. So, there's no place-based engagement team and they're really pressed to do that anymore… The [RCA] reductions are enormous on the place-based team… So all those connectors, all [the] glue that make[s] things happen, [is] not there in the way they were. And I think that puts colossal pressure on a very small management team, which is why I think the transformation meeting hasn't happened. They just haven't got the resource to pull it together. And I get

that [it] takes time to do those things. But then you start to miss the things that are really going to bring about change.

In response to the requirement to reduce running costs, the ICB in site B was undergoing a major restructure that would have significant implications for the leadership of the place-based partnership: essentially, the ICB was planning to centralise the leadership of the three place-based partnerships within the system. At the time of our interviews, that was a very live and controversial issue for partners working at place level. Understandably, they spoke of their concerns about no longer having a dedicated lead for the place-based partnership (an individual who many expressed their admiration and respect for), and the extent to which place-level issues would factor in decisions being made at system level.

In site C, one partner (the SPoA) said some (unspecified) projects or programmes have been reduced or withdrawn, which has an impact on outcomes, as well as confidence levels among partners at place level. The leader said the advantage of the place-based partnership being hosted in a non-NHS organisation (essentially being off the ICB's books) meant that a number of commissioning staff were able to be retained through grant funding. However, the leader acknowledged that meeting the 30% target for the ICB would have a major impact in future on what is feasible to achieve at place level, and perhaps place-based partnerships would cease to exist altogether. According to the leader, ultimately people would pay the price:

So, it will impact the community, it will mean that at the moment, the way that our health and care partnership works and the way that the team works means that we do things at community level. We do things at grassroot level. We make a difference to people. And we're starting to see that difference, we're starting to see a bit of a turn and shift in things like… cancer screening, because we're getting to know the communities and finding out the blocks… You know, our marginalised groups, we've got really good relationships with our [Roma, Gypsy and Traveller] community, our Ghanaian groups, our Ukrainian refugee groups, our homeless population. We've got people that have been homeless for years and years and haven't been going into… you know, they've been using acute, as in going into [A&E], but they haven't been having their regular check-ups and all their preventive stuff, and we've got people that were going into [A&E] three, four times a week and are now in temporary accommodation… The real stuff that is making a difference to human beings and their lives and the lives of the people around them, that you will lose.

8 Relationships and partnership working

In this section, we consider what partners in all three sites had to say about their relationships and ways of working with each other, the successes and challenges associated with this, the interface with the ICB, and what they believe will help fortify place-based working.

> *What gives me hope is that, notwithstanding all the challenges, we've got really good people in the city. We're not cosy. People are willing to challenge each other, people are willing to ask difficult questions, but also people are ultimately supportive and I think link back to the city goals… A lot of commitment to the city and to the people within it, and particularly to tackling very entrenched inequality and disadvantage… It can feel like we've all got our hands tied behind our back.*

The importance of relationships

The focus at place level in all three sites on tackling health inequalities, the wider determinants of health, and prevention was felt to require a different 'truly collaborative' approach. Drawing on the various perspectives, skills and assets of different partners and generating momentum for change within and led by communities, partners spoke with enthusiasm about the potential for place-based partnerships to signal a move towards a more creative and adventurous way of working. One partner described the approach of working at place as 'more of a relational one than a formal and contractual one'. And, as another partner put it, prioritising relationships and working in this way was the only way that 'things were going to change'.

In one site, the leader of a place-based partnership said it had been a 'conscious decision' to spend time on relationship-building to ensure that all partners feel they are 'in the tent' and understand each other, as well as their shared goals and aims in working together. For partners who described having less experience of

this level of partnership working, including VCSE sector, Healthwatch and primary care partners, this was helpful in equipping them to be able to take part in conversations with other partners (conversations which, for some, could sometimes 'go over my head'). Relationship-building efforts included holding 'development days' and knowledge exchanges where different partners shared their thinking and experiences in relation to issues affecting partners and places. Building this understanding of each other would, it was hoped, result in partners feeling invested personally in supporting each other and, simultaneously, feeling that their own needs were recognised and met. This principle of mutuality was felt to be an important factor in securing the buy-in of very senior people within partner organisations so that they prioritise coming to place meetings and have a sense of 'what is in it for me'.

> *There's a massive OD [organisational development] piece [in] this. You can't just expect people to be different. You've got to give people a joint purpose. People have got to buy into it themselves. You can't tell people what to do. What are the benefits for the population, for the staff, for the organisations, how do people have skin in the game?*

Some partners (especially the leaders of place-based partnerships) felt that, in the health and care sector, relationships can often be underestimated and consigned to the realm of 'soft stuff'. We heard that it was precisely this 'softness' and 'informality' that was felt to be key in partners getting to know, trust and work together to 'get things done'. A 'harder' approach characterised by more formal structures and accountability would, they said, potentially undermine partners' ability to bond and to work together to meet local needs in a flexible way.

> *We can have the best model in place, but if you don't have the relationships, you're not going to execute any of these things. And I think, in the formation of place-based partnership, under the new place director, what we saw was a real, renewed focus on trust, relationship, collaboration, in a way that we haven't seen before. So I think that was fundamental.*

The benefits of strong working relationships

We heard numerous examples where partners felt relationships had made it possible to leverage meaningful change – including in ways that extend beyond 'classic health', which inferred doing more than treating illness. In turn, the visibility of this change generated its own success and increased the momentum behind existing programmes of work. Some examples of these programmes were set out earlier, in Section 6, 'What are place-based partnerships doing?'

There were some broad types of impact partners had observed at place, including the following:

- **Their impact on each other, their ways of working and organisational priorities.** Through understanding each other better and embarking on a mission with a shared purpose, we heard examples where partners had found more collaborative ways to: make decisions about how to allocate the BCF; engage with parts of the sector that have previously felt they were not adequately involved, such as primary care; and, in one case, realign the organisational strategy with that of the place-based partnership.
- **Stronger links with community-based organisations and underserved populations.** All three sites had undertaken listening and engagement exercises with the public, spearheaded by VCSE sector organisations, leading to an enhanced understanding of need, and options to deliver more effective interventions for communities experiencing the worst health outcomes.
- **Reviewing, redesigning and setting up new services, and addressing gaps in need.** We heard a number of examples of this in relation to children's neurodevelopment care pathways, end-of-life care for children and young people, establishing a new tier 3 healthy weight service, diabetes and respiratory services, and reducing delayed discharge from hospital. We heard that these projects tended to be characterised by 'very effective cross-sector engagement', involving stakeholders across acute care, the local authority, ambulatory care, community and mental health services, education providers and housing associations. One site adopted a 'commissioning cycle' approach, which comprised a needs assessment of the local population, review of existing service design, assets and gaps (including staffing and finances), development of a new service specification, and discussions about which providers were best placed to deliver care in a more effective way.

In each of these cases, partners tended to speak about impact in qualitative, human terms: that it is measured in the experiences and testimony of those who live in, and whose health might be adversely impacted by, their local places and communities.

> *It makes a difference to people, that's what place does. You can sit in front of a computer, you can write a spec, you can do it on a screen without visiting that community. But the real stuff that is making a difference to human beings and their lives and the lives of the people around them…*

There was an acknowledgement that it was neither quick nor easy to measure the success of the work of place-based partnerships in making meaningful changes upstream. More commonly, some partners said that the scale of the ambition for the 'wholesale transformation of services' to address health inequalities and the wider determinants of health could lead to feeling dispirited and focusing instead on slow progress. One interviewee suggested that partners need to have 'realistic expectations' of what can feasibly be achieved from one meeting to the next, especially as each partner is also facing their own challenges.

> *It's always a time factor, isn't it? Funding and time and a willingness for people to listen and to be shown with good examples of how this can work for them. And once they engage with it themselves, them personally, it's experiencing how it can work for them. It has to be part of their engagement that they'll see it for themselves, so to speak. So yes, I'd like to have more impact in doing that, but I think it's probably not going to happen. Not this year, maybe next year, who knows?*

The impact of power dynamics at place level

Some partners acknowledged that it was part and parcel of working with a range of different people, each bringing different perspectives and ideas, that there would be 'tensions' and disagreement. Whereas some felt the place-based partnership was able to host these honest, open and 'difficult' conversations, others were concerned that interactions at place level hover at a fairly polite level: that there was an aversion to airing partners' different, perhaps competing, interests and incentives, and a playing down of issues that might lead to potential conflict. Where one partner expressed dissent with a proposed course of action, they said they were badged as being 'provocative' and 'awkward to work with'. And while navigating the web of different partners' priorities was expected to be neither comfortable

nor easy, *not* exploring these openly left some partners with the sense that the dynamics of place were being shaped by an undercurrent of unspoken notions and assumptions of where power lies. These perceptions were shaped by various things:

- The amount of money and resource at the disposal of some partners more than others (specifically, partners representing acute providers and the local authority).
- Historic or ongoing relationships whereby one partner is commissioned by another partner or is directly answerable to elected members on the partnership.
- Wider pressures – for instance, the national impetus towards addressing issues pertaining to waiting lists, delayed discharge, and urgent and emergency care attendances, for which some partners are publicly held to account.

In the face of a host of wider systemic and contextual pressures, and as places continue to establish themselves within their local systems, there was a sense that existing structures and ways of working made working relationships between partners all the more difficult and stacked the odds against the primacy of place as a locus for change. Partners identified some of the obstacles to effective partnership working at place level as follows:

- **The national policy context, including the existing legislation and guidance pertaining to place, which were felt to bind places to an NHS-centric (largely hospital-dominated) agenda.** This left little room for partners at place level to feel they could prioritise the more lateral, longer-term work of prevention, which necessarily relied on 'softer' approaches such as building relationships with communities and clinicians.
- **Very limited finances and resource to work with at place level.** Partners said they were expected to add place-based working to their existing plate of work and budgets and, as a consequence, delivery happened by 'serendipity rather than by design'. We heard that partners were so preoccupied by their own pressures that it perpetuated 'protectionist', risk-averse and short-termist behaviour. This included examples where some partners exhibited a reluctance to share their budgets or redesign care pathways where there was a concern that this would affect their income.

- **Enduring differences in culture, and the levers for change within individual partner organisations and between different parts of the sector.** One partner described there being 'turf wars' between partners, both in terms of agreeing a set of shared priorities (rather, it felt like each partner had a priority of their own) and on how best to execute and deliver the vision for change. 'Our worlds are really different,' said one partner, referring to the difficulties in delivering change consistently where partner organisations have very different compositions and memberships; several others spoke about differences in the use of language, which meant that partners sometimes talked at cross purposes (eg, who is 'the community'?).

In the absence of clear expectations and resources to support the work of place, partners attributed the success of place-level projects to the contributions of significant individuals and personalities. In particular, we heard positive feedback about the leaders of place-based partnerships. Consistently, other partners spoke with appreciation for the leaders' ability to bring partners together and try to draw out different viewpoints, and to represent the partnership and advocate for the local population in forums such as the ICB Executive; and for their openness and transparency, and their proactive, can-do energy.

Just as significantly, we heard examples where other individuals and personalities had been felt to obstruct work at place level (for instance, where they prioritised their own personal or organisational interests above those of the collective). In one site, we heard about instances where a partner indicated their agreement with a course of action but then repeatedly did not follow through on their word beyond the meeting. A reliance on relationships and personalities alone, therefore, meant that some partners were concerned about how 'fragile' place-based arrangements were: specifically, how partners came together to fulfil their shared purpose amid competing interests, priorities and challenges while also holding themselves and each other to account for their work together at place; and for the partnership as a whole in relation to other agencies such as the ICB.

> *[A] lot of this work can usually only be achieved by rapport of individuals, so developing those relationships and building trust. If they're constantly changing that, that's a problem… My worry is it's evolved and it's down to individuals rather than any core structure. So if key individuals change, I think it's then going*

to be back to the drawing board and starting again. I don't think we've evolved necessarily as a system… [M]y concern is it's down to individuals and that individual rapport with each other rather than anything systematic.

The relationship between place-based partnerships and ICBs

The relationship with the ICB was possibly the most commonly cited barrier in terms of being able to achieve anything meaningful at place. This relationship was typically characterised by misunderstanding and misalignment: that neither the place-based partnership nor the ICB really understand what the other does; and that they seem to speak different languages and have different areas of interest that, so far, it has not been possible to bridge. Direct contact between the partnership and the ICB Executive tended to be infrequent and limited, with the leader of the place-based partnership acting as a conduit. Having said that, we also heard examples where the leaders of the place-based partnerships felt they had been repeatedly ignored by their points of contact in the ICB and, in the most extreme cases, were at the receiving end of some hostility (one leader described comments aimed at them 'about putting me back in my box and that I need to do what I'm told'). Without a consistent or an open channel of communication with colleagues at ICB level, this left many partners at place level with a sense of powerlessness, feeling that they were removed from, and unable to influence, decisions about money and the system-wide strategy. This finding was consistent across all three case study sites irrespective of their governance arrangements, although partners reported feeling a particularly keen sense of powerlessness in site C, where there was no delegation of function and budget to place level.

It was common for partners to see the difficulties in the relationship between place-based partnerships and ICBs as indicative of a clash in purpose and role: on the one hand, a top-down, accountability-heavy infrastructure concerned about reducing unwarranted variation from one place to another; and on the other, locally driven decisions about how to improve the health of the most underserved communities. In some sites, this resulted in a strong sense of identity of place as *in opposition to* the ICB. Although this acted as a glue of sorts between place-based partners, some recognised that it undermined the potential for a productive relationship between the two levels. While some partners recognised that ICBs and place-based partnerships might have different but complementary remits, we heard that relational difficulties between the two led to a much more adversarial

dynamic in which a partner in one site described being treated like 'a naughty child'. Generally, this dynamic was perceived to be driven by the 'command and control' approach of the ICB and an unwillingness to cede power, functions or budget to place level.

Partners interpreted this as a feature of how ICBs themselves are held to account by NHS England. Unfortunately, this left partners feeling that the ICB treated place as an extension of the NHS and was 'obsessed' with winter pressures, patient flow and, often, its own 'terrible financial position'. Partners described feeling 'written off' by the ICB in some cases, being told to 'do as you are told'. Where partners felt proud of what they had been able to achieve at place level, they felt they had been forced to 'work around' and 'subvert' the ICB.

> *It's really sad because I've worked in this system for 30 years and it's the first time ever in the whole of my career that I don't believe in where the NHS is going. And that's not the national picture because I get where things are nationally, but I do think that we could turn this around locally if we had people that were driving that agenda, but they're not. So, for me, at local level, it either implodes really, really soon or something fundamental changes.*

In two sites, we heard that the ICB's own preoccupations and priorities have more actively undermined work at place. Mainly, these preoccupations were understood to be financial – what one partner described as a 'laser focus' on curbing spend and making the 30% RCA reductions. These cuts were believed to underlie decisions such as:

- removing the role of the leader of the place-based partnership in one site
- ceasing health inequalities funding at short notice and without warning
- closing local services without consultation
- reducing the size of place-based teams.

Two sites had raised formal grievances about what they perceived to be unjust and obstructive behaviour thwarting the work that might be done at place. They had not, at the time of this research, received any response (with one site saying their emails to their contact in the ICB were 'blanked' twice).

We note here that our interview topic guide covered the relationship between places and ICBs; however, it did not cover the relationship with integrated care partnerships (ICPs). Yet it is striking that the topic of ICPs did not come up in the course of any of our interviews. Therefore, not only is it difficult to describe relationships between place-based partnerships and ICPs (and how they compared with relationships to ICBs), but the ICP relationship seems conspicuous by its absence in our data.

National policy and leadership

Underlying the tensions outlined above was the sense among partners working at place level that place is not valued or taken seriously by the ICBs and, more generally, national policy. Despite the broad goodwill and enthusiasm we heard among partners for working together in a different way, there was a sense that place-based partnerships lacked the power and 'teeth' to thrive within existing structures, wider pressures and top-down mechanisms of understanding, delivering and measuring change. Without prompting, several partners said they felt national policy needed to recognise and endorse place as a locus for change and, in doing so, fortify and empower place-based partners to invest their time, energy and resources in doing the essential relational work that is needed to deliver meaningful change from the ground up. Some partners felt that the present political climate offered an opportune moment to seize on the rhetoric of focusing on prevention, and moving care closer to home (as per the 10 Year Health Plan) and empowering communities. This shift in policy would, some partners hoped, pave the way to alternative approaches to funding and accountability in a way that allows place to play to its strengths rather than trying to fit into a traditional NHS-centric model.

For some partners, there was a role for national policy to set out more clearly the envisioned roles and responsibilities of ICBs and place-based partnerships, as well as guidance about when and how the two should interact. This relationship would, ideally, be characterised by co-operation, with place-based partnerships being treated as a trusted forum for partners to get to the heart of the historical challenge (and repeated aim) of improving health and not only treating illness. It is worth emphasising that partners did not envisage the role of national policy as one of ensnaring place-based partnerships within more of the same formal top-down accountability structures. Rather, one partner described the role of national policy as offering 'air cover' – supporting place-based partners to navigate their existing

responsibilities and organisational pressures *and* come together to work towards a collective goal at place level. It would also signal to bodies such as ICBs the importance of striking a balance between short-term urgent issues (eg, waiting lists) and long-term reform (eg, prevention and tackling health inequalities).

> *We are stubborn and we will keep fighting, we won't walk away from this but I'm really hoping to get the policy backing because this could be game-changing, absolutely could be game-changing but… if we can't get the support from the ICB, then we need the policy support. I'm not one who begs for policy… But I could really do with some policy backing about how we're going to get taken seriously… I could really do with some policy and some focus on, not just the words but actually doing subsidiarity, delegation. An ICB that behaves as a system leader, not a system manager.*

Partners offered some further suggestions about the practical steps that might enable them to better navigate some of the challenges they had encountered in their ways of working with each other:

- Mandatory place representation on the ICB board (with voting rights).
- A requirement that the chair of the partnership is independent of any major players at place level (to mitigate the risk that they abuse their position to advance their own interests at the expense of the partnership as a whole).
- Clearer guidance about how place-based partnerships might manoeuvre their resources in a more shared way (ie, to help break out of established ways of thinking about how pooled budgets could or should be used).
- Organisational development support to help build relationships, promote better understanding of each other, and help partners who are less well versed in forums like this to find their voice.
- Better communications and engagement with stakeholders across health and care to showcase what is being/can be achieved at place.

9 Conclusion and recommendations

We have set out the ambitions for place-based partnerships and looked in detail into how they are set up and resourced to fulfil those aims, as well as the challenges they have experienced. There is considerable enthusiasm and motivation at place level; however, findings from our survey of place-based partnership leaders and interviews at the three case study sites do not suggest that these aims are being met or, as things currently stand, are on track to be met in the future. That is not to cast blame; developing health and care as integrated 'systems within systems' (Ham and Alderwick 2015) has always been a complex proposition, and the challenging, non-linear nature of partnership working is well known.

More positively, our findings also offer insights that may help with achieving the potential of place-based partnerships. That is just as well, since the government's approach to transforming the NHS (Streeting 2024) and its plans for a neighbourhood health service (NHS England 2025a) – both published after this research had started – have made place-based partnerships more important than ever and upped the stakes on their needing to deliver.

Our insights build on and reinforce the conclusions of previous research (Charles *et al* 2021), which indicates that place-based partnerships are an essential part of ICSs and the right locus for many aspects of service transformation and reform – provided they are adequately enabled and supported. We have grouped our insights into four themes, with the intention that they should support course correction and maximise the opportunities from emerging developments in national policy. The themes are:

- a clear focus with protected space for reform
- accountability
- collaborative leadership
- resources.

A clear focus with protected space for reform

Several interviewees told us their top ask of national policy would be to reinforce the status of place-based partnerships and expectations of support for them. Place-based partnerships being overruled explicitly by ICBs, and more subtly by some partner organisations' priorities, were repeated themes in both the survey and the case studies. All three case study sites believed that their effectiveness would be limited by insufficient clarity about the expectations for them to lead transformation and reform, and lack of buy-in to their authority to deliver these.

Fundamentally, the case studies drew out a picture of differing views and experiences of how place-based partnerships fit into the overall health and care system – the extent to which they are a delivery mechanism for decisions made at system or regional level, or the designers of how a strategic direction translates into practice. ICBs had a particularly inconstant focus, with both our survey and our case study sites indicating they could be key enablers of place-based partnerships but also actively inhibit their progress when other priorities (such as waiting times performance or financial pressures) took precedence. Recent plans to refocus ICBs' role on strategic commissioning and remove their performance management role offer an opportunity to remove this conflict and create space for ICBs to focus consistently on a clear purpose of supporting service transformation by place-based partnerships. At the time of writing, further detail is awaited through a strategic commissioning framework due later in 2025, but there have also been confusing signals that higher-performing NHS trusts may take on this strategic role in some areas (NHS England 2025b). It is essential to separate out and delineate potentially conflicting priorities, so that urgent shorter-term priorities do not take up all the capacity with no space left for longer-term transformation and reform.

Recent guidance on a neighbourhood health service (NHS England 2025a) strikes a different balance to previous guidance for place-based partnerships. While still allowing for and emphasising local flexibility, it provides more operational detail and direction. This greater clarity of focus and expectation in national guidance is likely to be helpful in the current context of competing priorities and at this stage of partnerships' maturity.

Recommendations for national bodies

- Some of the key things that systems need to achieve are best done at place level, particularly when it comes to prevention, tackling health inequalities and redesigning out-of-hospital care. Future guidance and the forthcoming strategic commissioning framework should reinforce the purpose and role of place-based partnerships in planning and priority setting; it should send a clear signal about the value of place-based partnerships.
- Future guidance and the strategic commissioning framework should be as clear as possible on how place-based partnerships fit into a changing landscape in which ICBs are strategic commissioners.
- The guidance and framework should ensure that through clear delineation of competing responsibilities, urgent issues do not unduly prevent progress on long-term ones, and it should clarify both the authority that place-based partnerships have to lead reform and expectations for the rest of the health and care system to support them.

Accountability

Around half of survey respondents said they had a shared outcomes framework in place, but from the free-text comments and our case studies, it is likely that all place-based partnerships have some form of shared plan, although many choose not to use the model or name of a shared outcomes framework.

Similarly, it is likely that all place-based partnerships have some form of governance arrangement in place, but they appear to vary widely and often do not represent the models proposed nationally, including a single person of accountability (SPoA) (the most common survey response was 'a combination' of the different models). Our interviews found variability in the effectiveness of governance arrangements, including: uncertainty about how decisions really get made and whether they get implemented; perceptions that when it comes to it, partners are more accountable to their home organisations than to following through place-based partnership decisions; and power imbalances leading to decisions pushed through without some partners' support. Overall, it appeared that governance arrangements were not consistently reinforcing and requiring the depth of collaborative behaviours that

is needed, and could just be 'talking shop' meetings if the partners were not able or willing to ensure the capacity or resources for decisions to be followed through. This 'triangle' of accountability, collaborative partnering and resources is essential, but it is complex to make progress on all three fronts at the same time. We discuss the other two elements further below.

There are different traditions of how accountability works in the NHS, local authorities and VCSE organisations, and the approach that our interviewees seemed to favour was not one in which a single sector's approach dominates and the others fit in. Equally, they did not see it as sustainable to rely on individual place leaders to oversee every action. What they lacked was an approach in which partners could hold each other to account from their different perspectives, and a way of making accountability more of an enabler rather than just a control. The King's Fund has previously recommended that accountability arrangements should review not just performance against delivery plans but also the behaviours and principles that partners have signed up to, including regularly questioning and counterbalancing the NHS's dominance in whole-system approaches (Naylor *et al* 2024). In addition, this idea of mutual accountability for whole-system performance is not new (Local Government Association 2024). However, while acknowledging that there is no simple fix and circumstances will be different in each place, there is still little in the way of guidance or clarity about how to make these ideas work in practice.

When carrying out our survey, we had to search public records to identify place leaders and their contact details, as there is no national database. Because place-based partnerships are not statutory bodies, they are under no obligation to publish details of their plans, performance, meetings or senior officers, and we found substantial variation in the availability of information. Many places clearly sought to involve communities in their work and to report on what they are doing, but some were difficult to access and published little information. There is more that could be done to promote openness and accountability at place level.

Finally, in our case study site interviews, none of the interviewees other than the place leader could generally recall the priorities in their partnership's plan. Without wanting to constrain partnerships' ambitions, the breadth of some partnerships' plans may have made an already complex landscape of organisational

and partnership accountability and multiple oversight processes and committees even more complicated. Furthermore, in the context of still developing maturity as partners are learning how to make mutual accountability work, there may be merit in focusing on just a small number of issues that offer the richest learning.

Recommendations for national bodies

- There is a need for engagement with place-based partnerships to develop resources and guidance on stronger governance and accountability at place level that also supports the development of new ways of working. This should particularly include:
    - mutual accountability (for behaviours and outcomes), as well as the support needed for transitioning to this way of working (eg, case studies)
    - accountability to communities (including certain mandatory basics, such as publishing names of partnership leaders/SPoAs and plans or strategies, as well as developing responsive capability to different communities).
- The separation of performance management and strategic commissioning roles is an opportunity to ensure that accountability above place level reflects the right balance of focus on both shorter-and longer-term priorities, and on NHS organisations' performance and whole-system performance.

Recommendations for place-based partnerships

- As there are limited resources on mutual accountability, place-based partnerships will need to develop 'test and learn' approaches (which could also help inform any future guidance).
- Even though they are not statutory bodies, place-based partnerships should consider how they are accountable to their local communities and compare themselves to others.
- Partnerships should review whether they make most progress through broad, ambitious plans or whether initially focusing on just a small number of priorities would enable greater opportunities to follow through transformation plans in practice and learn new ways of working together.

Collaborative leadership

Integrated, community-driven systems that build health rather than just health care are not created by bold policy statements but, in reality, by a large number of often individually small changes at a local level right along pathways of care and services (Charles *et al* 2021). Making and sustaining these changes in services and in ways of working requires skilled leadership, and this is a key issue to focus on in order to maximise the impact of place-based partnerships. Our analysis has found that within an overall context of building trust and relationships, leaders in the partner organisations need to focus on four things: surfacing and managing conflict; managing power dynamics; developing shared decision-making and accountability; and regularly checking in on the shared purpose and principles for working together (Walsh and de Sarandy 2023). All of these were evident in our case study sites and are normal challenges in partnership working.

Resources are available for developing collaborative leadership (for example, Fenney *et al* 2023 on power dynamics) although, as is often said, this is a long-term process that can never be ticked off as 'done'. However, our case studies illustrate that the need for collaborative leadership goes beyond individuals in partner organisations. Place-based partnerships are designed to have a bottom-up, community-driven approach that will inevitably be in tension with the NHS's top-down priorities. That tension is not necessarily a problem, but it will require some common understanding between place-based partnerships and the levels of NHS hierarchy above them and, to some extent, it goes against the long-standing and prevailing culture within the NHS.

Recommendation for national bodies

- It would be useful to consider place-based integration as a process of cultural change, as well as a process of developing services. DHSC and NHS England should reflect that in their leadership frameworks and in how national leaders 'set the tone', and in addition national guidance should say more about expected behaviours and ways of working across levels of the NHS hierarchy.

Recommendation for place-based partnerships

- Although there can be a natural desire to focus on delivering results, it is also essential to invest time and effort in developing collaborative leadership within the partnership and, especially as they become strategic commissioners, with ICBs.

Resources

Responses to our survey varied widely, from full delegation of budgets to partial delegation or no plans for delegation. It seems unlikely that place-based partnerships could achieve the government's overall aims without any delegated functions or budgets. None of the respondents felt there was excessive delegation of budgets or functions, and the most common view was that there was too little delegation of both. In both the survey and the case study interviews, there was definite interest and appetite for greater delegation among place-based partnerships. But both also made clear that some ICBs are unwilling to cede control over functions and budgets, and that to manage their financial pressures, some ICBs prioritise short-term urgent issues (such as reducing running costs or waiting times) at the expense of the longer-term reform that place-based partnerships aspire to. This included examples of ICBs taking back funds or functions that had previously been delegated to the place-based partnership.

Although place-based partnerships wanted greater delegation, they were cautious about achieving that through a top-down mandate. They told us that a blanket approach might not work unless there was assurance that there would be capacity and capability to manage the budgets and functions in all place-based partnerships. They also told us it would be risky to require delegation where there are extreme financial challenges, where NHS trusts or ICBs are in the highest level of financial oversight, or where there are poor or dysfunctional relationships between partners or between the place-based partnership and the ICB.

Although there were some exceptions (both positive and negative), our survey suggests no overall increase in levels of pooled and aligned funding since place-based partnerships were set up. Financial pressures, complex governance and negative influence from ICBs were given as key reasons. Our case studies

paint the same picture and also illustrate how in some places the approach to pooling budgets may still be developing rather than being a mature, embedded way of working, with technical complexities a key limiting factor. This is in line with findings of the Hewitt review (Department of Health and Social Care 2023b), which found some arrangements excessively bureaucratic, and the range of budgets that can be pooled too narrow.

Our case study sites included a few examples of shifts in investment, but overall it appeared to be a difficult proposition to follow through on aspirations for service transformation by redesigning whole pathways of care and shifting funding and resources to match. In the longer term, further development of collaborative leadership may help with this. In the shorter term, the change in ICBs' role as strategic commissioners and new national guidance on creating a neighbourhood health service (NHS England 2025a) are key opportunities for seeing whether more rebalancing of resources is possible.

Recommendations for national bodies

- Though simply mandating delegation of functions and budgets may not be appropriate, it may still be possible to go further by creating a scale of place-based partnership maturity, with an increasing expectation of delegated budgets and responsibilities as a partnership progresses and matures.
- In addition to the recommendations of the Hewitt review to simplify and broaden arrangements for pooling budgets, sharing examples of good practice and practical toolkits should help develop confidence in navigating the challenges involved in pooling more resources.

Appendix: Survey of place-based partnerships

Selected key topics from the survey are covered in Section 3 of this report. This appendix covers technical details about the survey and other survey findings.

Technical details about the survey

In late 2023, The King's Fund undertook some scoping interviews with a small number of place-based partnership leaders to test the feasibility of a large-scale survey. Following this scoping, we developed a survey tool for place-based partnership leaders to provide information and insights about place-level working.

The tool covered the following topics:

- leadership and accountability arrangements (ie, details about the leader and the single person of accountability)
- governance arrangements (ie, governance model and membership of the partnership)
- shared outcomes framework
- delegated functions and budgets/resources
- pooling of budgets
- working relationships (ie, nature of working relationships and challenges to partnership working)
- perceived progress (ie, the extent to which respondents felt their place-based partnership was working towards the goals and ambitions set out in *Thriving places*, the guidance produced by NHS England and the Local Government Association).

There are 180 place-based partnerships in England. Desk-based research generated contact details for 121 place-based leaders or ICB departments acting as proxies. The link to the survey was sent to the email addresses we had in May 2024, with additional promotion of the survey provided by the NHS Confederation and NHS Providers in their networks, and through The King's Fund's social media channels. The survey was closed in early June due to the announcement of the general election.

We received 78 survey responses. Some were not suitable for analysis – for example, where people had entered random or blank characters throughout. There were also cases where we received multiple entries from the same place-based partnership. In these cases, we retained only one entry for each, based on personal knowledge (eg, where The King's Fund research team knew who the leader was and retained only their response), or by contacting the individuals and asking for their view on which response to retain.

The final sample used for analysis contained 48 responses. Some respondents did not answer every question in the survey, and some questions allowed for multiple responses (ie, where respondents could tick all answers they deemed applicable). Therefore, not all response totals outlined will equal 48. We have included free-text responses where they provide further insight – albeit limited to brief sentences (shown as verbatim quotes). We advise that the comments quoted are treated with caution, as they are not generalisable.

Survey findings

Governance arrangements

As outlined in Section 3, most responses indicated that their governance model was a combination of different models. A small number of respondents indicated that the governance model was a combination of the following:

- place board + consultative forum
- consultative forum + committee of a statutory body
- committee of a statutory body + place board
- place board + consultative forum + ICB sub-committee with delegation for signing-off eg, Better Care Fund (BCF) and other joint budgets.

A small number of respondents indicated that their governance model was different from all the types listed, for example:

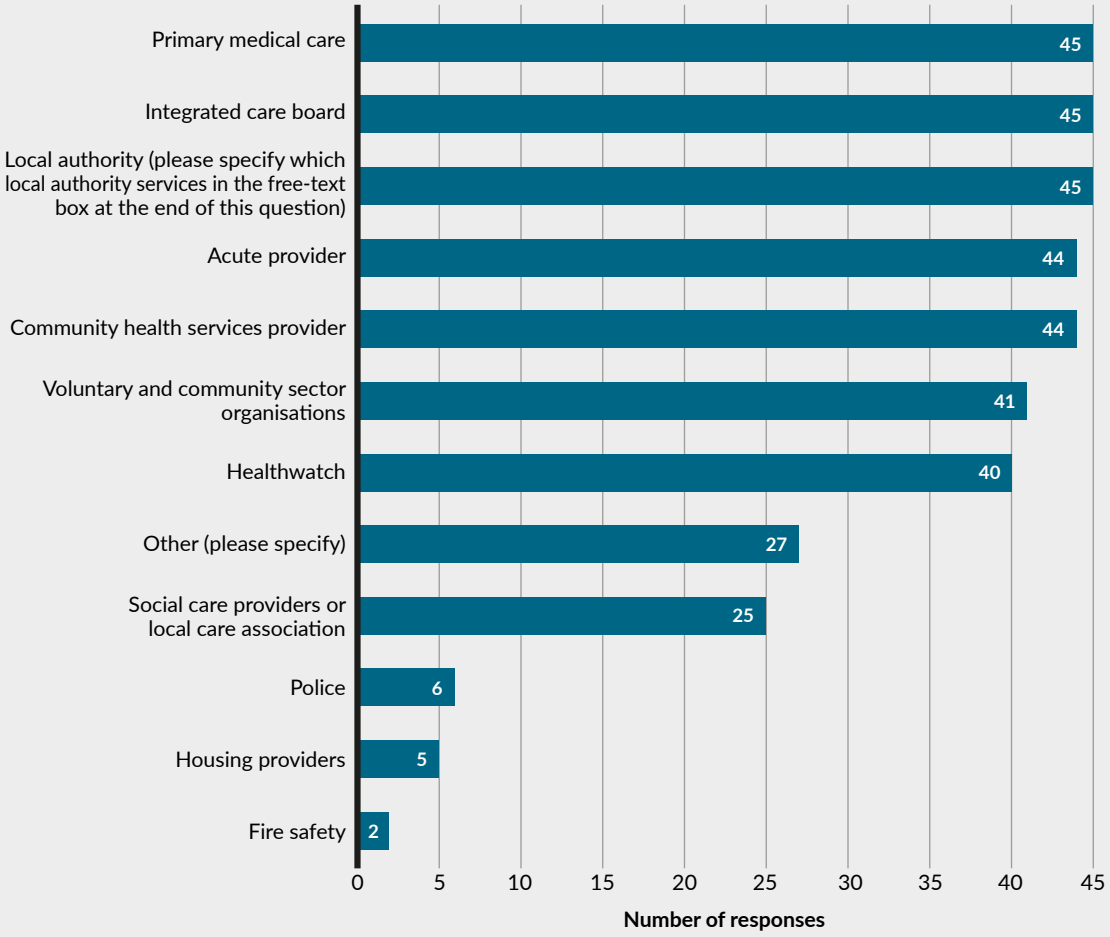
- 'Accountable business units'
- 'The place partnership has an ethos of equality between partners'
- 'MoU [memorandum of understanding] as still developing pathway to delegated budget'
- 'Work at place is facilitated by (the health and wellbeing board) and its sub-committees'
- 'No delegated budgets or powers yet. Place is focused on delivery of services using pop[ulation] health metrics'
- 'An integrated care alliance which works in a similar way to a consultative forum. Also a locality commissioning group (legacy of CCG [clinical commissioning group]) which has delegated authority to make decisions re: s75 agreements including the BCF'

Statutory NHS organisations (ICBs and trusts), primary medical care and local authorities were the most common members of place-based partnerships (Figure A1, p 67). Other members mentioned in free-text comments included: ambulance providers; armed forces representatives; housing leads (distinct from housing providers); mental health providers; and local universities. Where respondents used the free-text field to specify which local authority services were represented in the place-based partnership, the most commonly cited were:

- public health
- adult social care services
- children's social care services.

Figure A1 Membership of place-based partnerships

Which of the following are members of your place-based partnership?
Respondents were allowed to select more than one option.



Source: Survey by The King's Fund. Survey in the field May–June 2024

Shared outcomes framework

Just over half of respondents (25) said there was a shared outcomes framework (SOF) at place level. Some respondents who said there was currently no SOF noted that there was one being developed, or that an outcomes framework had been developed at system level, and place-based partnerships had programmes or delivery plans that aligned with these wider frameworks.

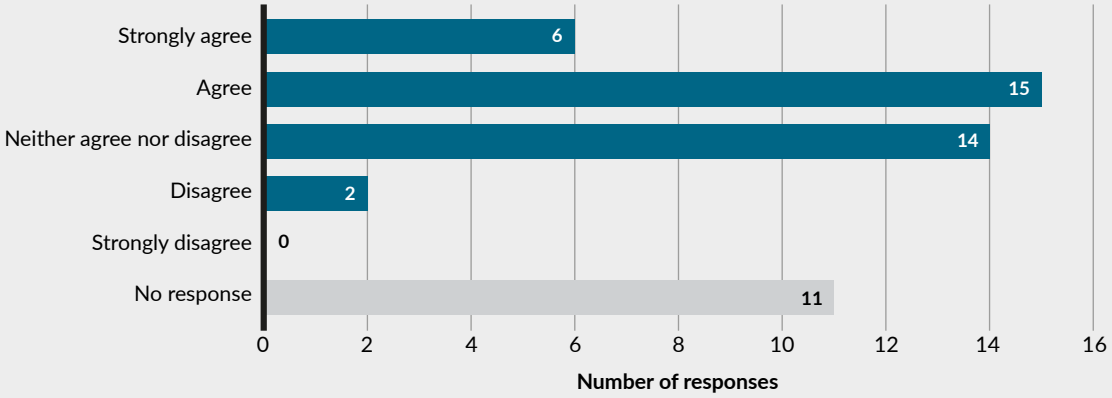
The survey asked leaders whether there were plans to develop a SOF. The following gives a flavour of the responses given in the free-text field:

- 'Not made much progress; support will be needed [doesn't specify what support/from whom]'
- 'Using the system-wide outcomes framework as well as outcomes aligned to place partnership's programme of work (NB: also developing a theory of change to understand value of focus on preventive and integrated approaches)'
- 'Using a delivery plan instead of formal outcomes framework'
- 'No formal shared outcomes framework and challenge to bring together ICP, ICB strategies and council plan but trying! Large footprint'
- 'The ICS has a shared outcomes framework, not individual place partnerships'
- 'Have delivery milestones and outcomes for the place ABU team. The place outcomes framework will dovetail into the ICS framework' [doesn't specify what ABU refers to]
- 'Place works under the [health and wellbeing board] which has metrics to be delivered. Place is developing metrics for its key priorities'
- 'Have a shared "Healthy [place name]" plan with common goals/priorities. The ICS is looking at a common approach'

Twenty respondents agreed or strongly agreed that the process of developing a SOF had encouraged partnership working. Fourteen neither agreed nor disagreed with the statement. Two respondents disagreed that partnership working had been encouraged by developing a SOF (Figure A2, p 69).

Figure A2 Shared outcomes framework and partnership working

If you have a shared outcomes framework, to what extent do you agree, or disagree, with the following statement: The process of developing a shared outcomes framework has encouraged partnership working?



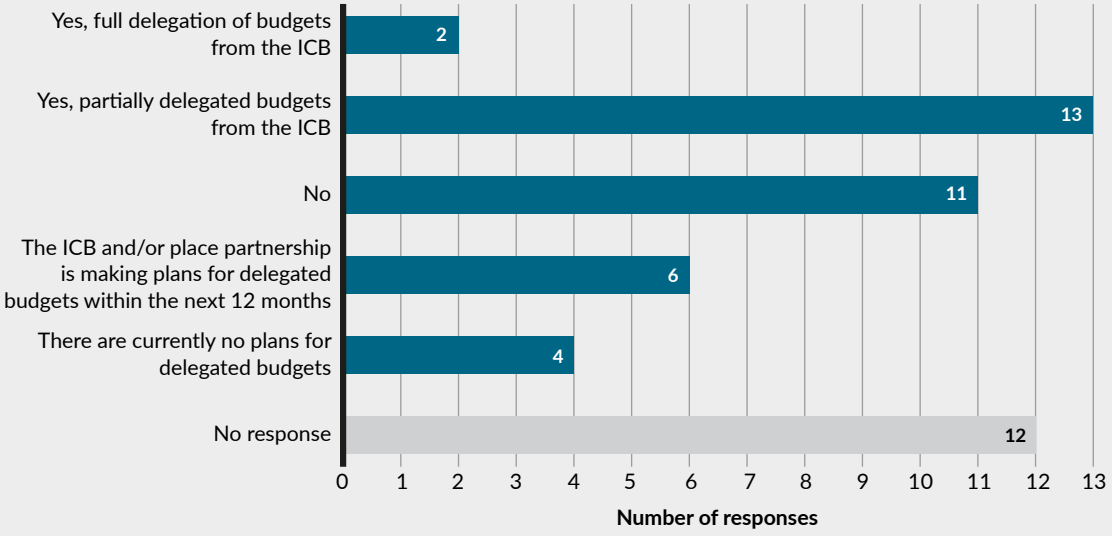
Source: Survey by The King's Fund. Survey in the field May–June 2024

Delegated budgets

The survey asked whether budgets had been delegated to the place-based partnership by the ICB (Figure A3).

Figure A3 Delegation of budgets from ICB to place level

Does your place have delegated budgets from the integrated care board?



Source: Survey by The King's Fund. Survey in the field May–June 2024

If respondents selected 'yes' for either fully or partially delegated budgets, they were asked to indicate in a free-text field what the budgets covered. The following responses were given, although it should be noted there were only 11 responses of this kind and we cannot suggest they reflect all place-based partnerships:

- Better Care Fund
- Community
- Primary care
- Local independent sector/VCSE sector contracts
- Winter resilience/winter discharge
- Medicines
- 'Out-of-hospital services' (but not specified)
- Mental health, physical disability, learning disability
- Additional discharge funding
- Urgent and emergency care funding
- Inequalities funding
- Delegated budget for the HIU programme
- Integrated neighbourhood
- Adult social care discharge
- Place resource

The survey asked for an indication of the overall budget of the ICS, and the amount of budget delegated to place level where applicable. Unfortunately, there was very little information provided here, and the quality of information provided was such that we cannot report meaningful results.

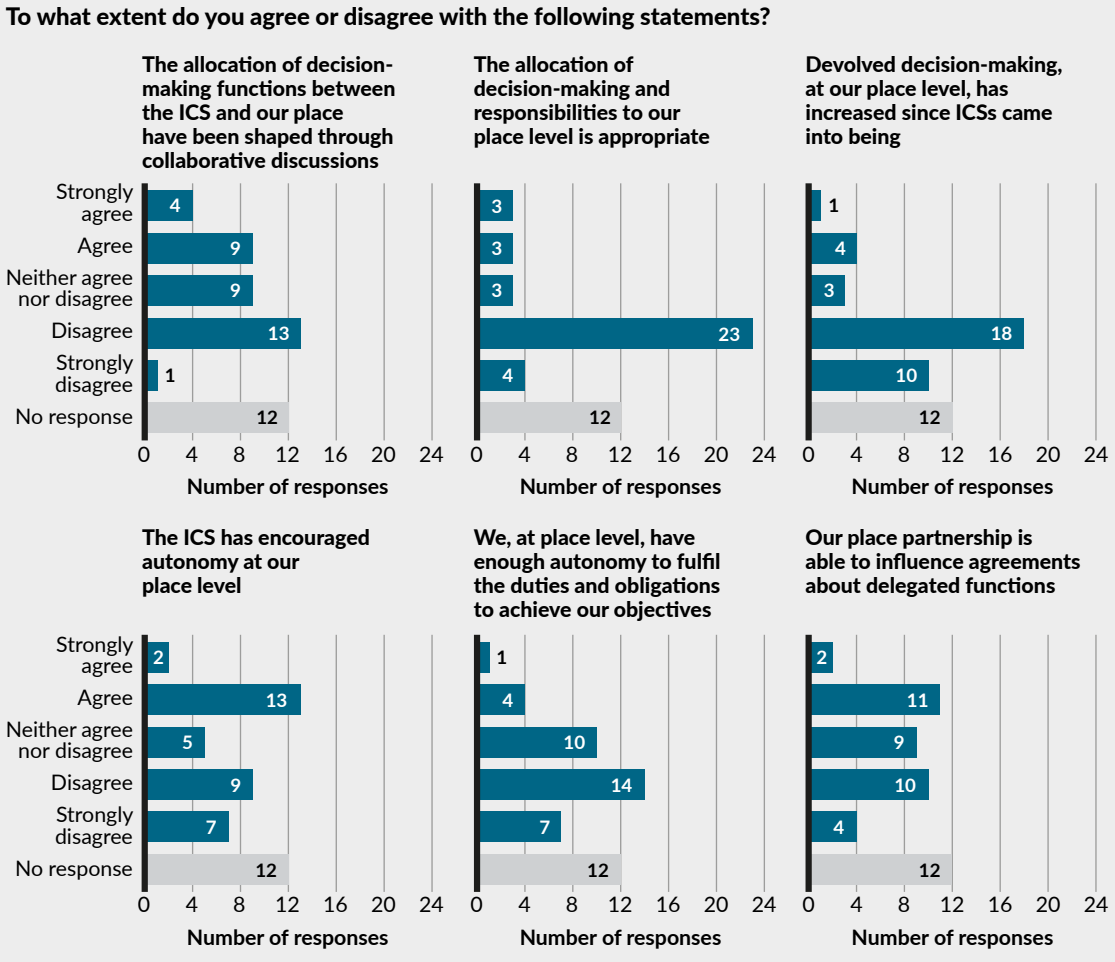
A small number of free-text responses indicated a plan for greater delegation of budgets in the future. Others noted that decision-making is complex due to involvement at both ICB and place levels:

> *The mechanisms of decision-making often involve a level of cross-management between the place board and the ICB with a feeling that delegation remains in a grey area.*

In another response, plans for delegation had been agreed in 2023 but then delayed due to 'the financial position and recovery requirements', and a timeframe for delegation had not been rescheduled.

Relatively few respondents thought that devolved decision-making, autonomy and influence on delegation agreements were strong or had increased at place level (Figure A4).

Figure A4 Perceptions about delegation of responsibilities, budgets and sense of autonomy and influence



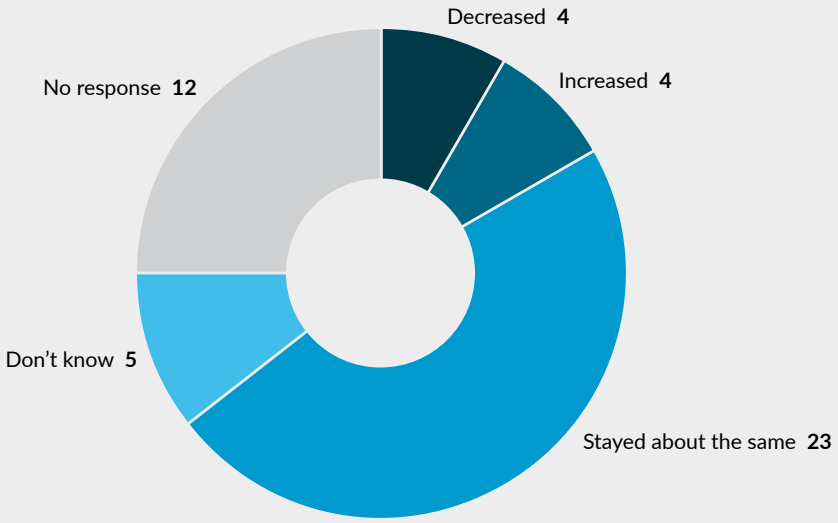
Source: Survey by The King's Fund. Survey in the field May–June 2024

Pooling of budgets

Since the creation of statutory ICSs in July 2022, the most common response from places was that the use of Section 75 arrangements (Figure A5) and pooled budgets under those arrangements (Figure A6, p 73) had stayed about the same. Financial pressures on NHS bodies and local authorities were the most common reasons cited by place-based partnership leaders when asked to name the main barriers to pooling budgets (Figure A7, p 73). (NB: the survey instrument asked respondents to select up to three options for this question but some respondents chose more than three options. We have displayed all the responses to this question, including where people chose more than three options.)

Figure A5 Use of Section 75 arrangements since July 2022

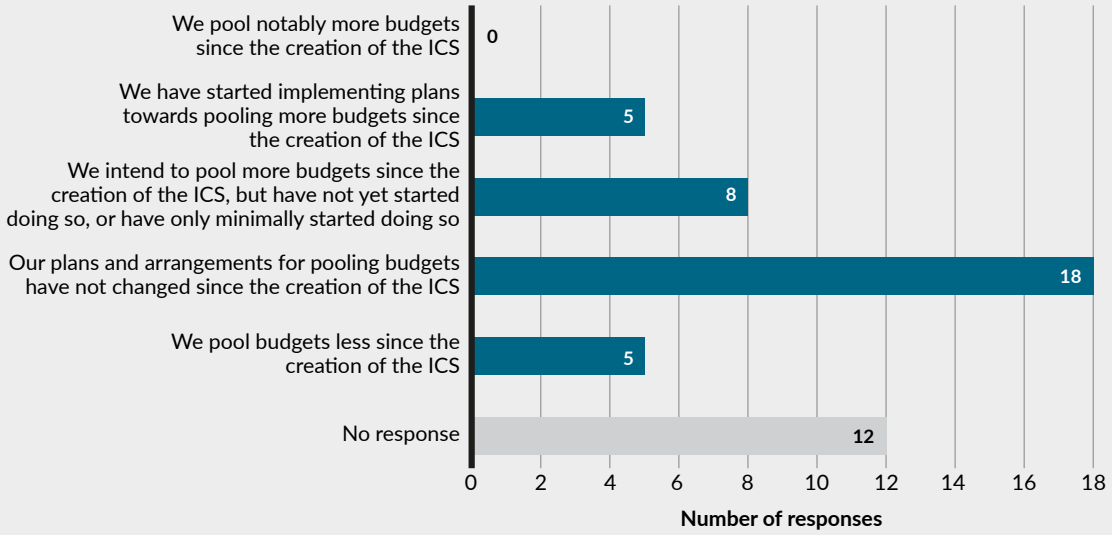
Since the creation of statutory ICSs in July 2022, how has the use of Section 75 arrangements between the local authorities and NHS bodies changed in your place?



Source: Survey by The King's Fund. Survey in the field May–June 2024

Figure A6 Experience of using Section 75 arrangements

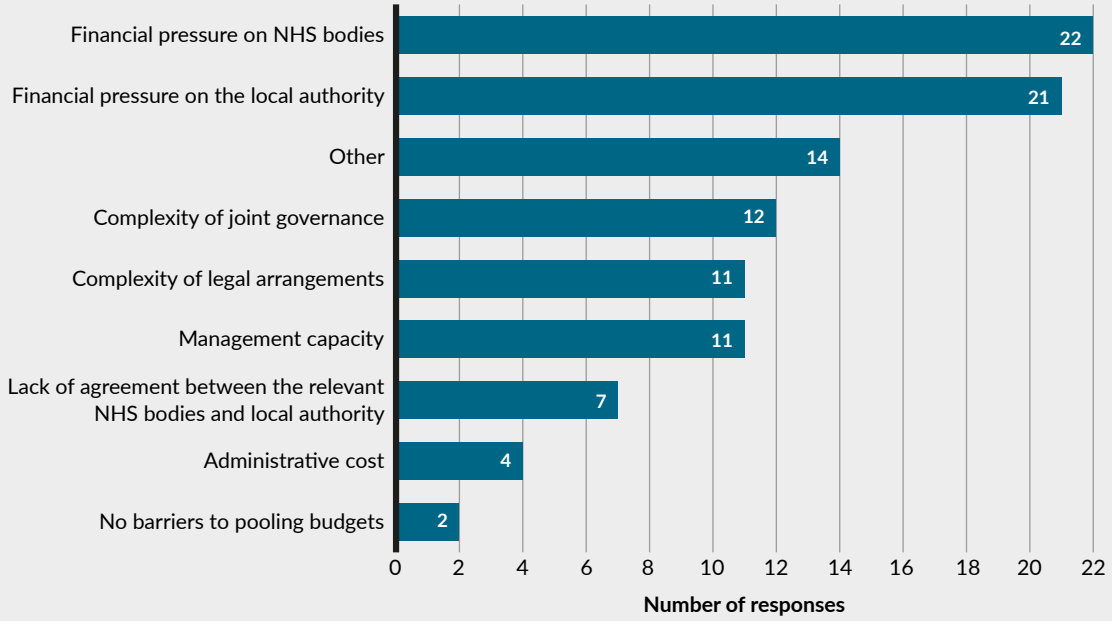
Thinking now about pooled budgets, which of these statements about the use of Section 75 best reflects experience in your place?



Source: Survey by The King's Fund. Survey in the field May–June 2024

Figure A7 Main barriers to pooling budgets

What, if any, are the main barriers to pooling budgets?
Respondents were allowed to select more than one option.



Source: Survey by The King's Fund. Survey in the field May–June 2024

Where respondents offered further information about barriers in the free-text field, a few responses focused on the culture or approach of the ICB. For example:

- 'Ideology of central control within the ICB'
- 'ICB over centralisation and control'

In other responses, it seemed the constraints were about structural differences between the NHS and local authorities, for example:

- 'Probably some cultural barriers, eg, experience of working as system, partnership, relationships and trust'
- 'Different regulatory requirements across health and local authority'

Some other responses indicated there is still some work required to enable processes (including the pooling of budgets) to become embedded in relatively new formal structures:

- 'Trying to bring equity in arrangements between councils across the ICS'

Finally, a couple of comments indicated that the place-based partnership leader was not convinced that pooling budgets was critical to achieve integration of care:

- 'Not sure they are necessary or as important as pooled budgets are often made out to be. The same outcome can be achieved with open book accounting and robust joint decision-making bodies'
- 'Whether there is a real benefit or the extent it is a management exercise? Jury out on existing arrangements which are low-key given the amount of integrated working we do'

Working relationships

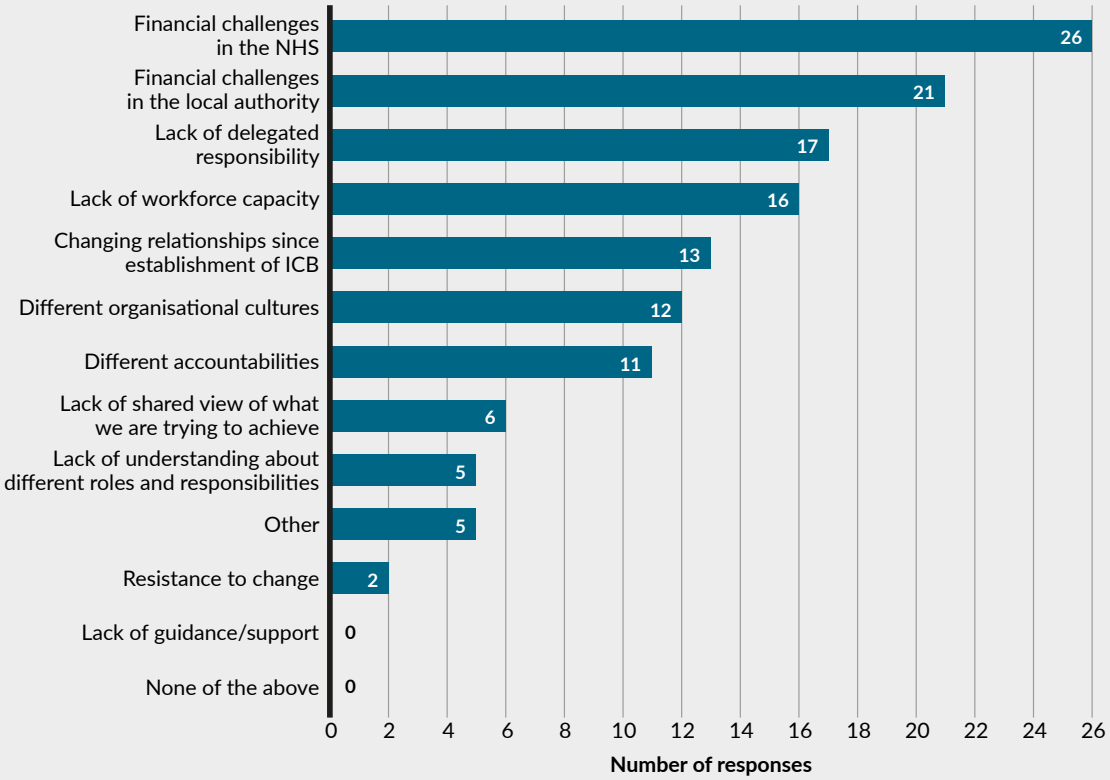
As we noted in Section 3, the most commonly used description of working relationships was 'definitely developing (currently variable depth)'. We have indicated below where a few respondents offered some further information in the free-text field about working relationships. Again, we caution against generalising. However, the comments do offer some useful insights:

- 'High levels of trust and partnership working with a strong sense of commitment and ambition'
- 'Want to bring more partners in'
- 'We have very good working relationships in a number of areas but need the opportunity to work collaboratively through delegated functions and budgets'
- 'Not all partners have moved at the same pace. There is still misunderstanding on "place" partnership vs CCG. This is especially relevant when understanding roles and responsibilities'
- 'While there is no formal delegation to place from the ICB we have a long and strong history of joined-up working across the NHS and council, previously coterminous with the CCG. We continue to build on our historical arrangements to strengthen joined up planning and delivery and improvements. Lack of delegation, clarity on accountability and' [incomplete entry]
- 'We have used a maturity matrix to self-assess progress of our partnership (I think this constitutes our SOF)'
- 'The soft partnership elements are really strong. Everyone gets on, we can have open and challenging constructive conversations. There is strong trust between partners. Some smaller joint working has taken place and been successful. We are [influencing] system work. The big ticket items around delegated commissioning and realigning resources to place and prevention are happening but not much action'

As with questions on pooled budgets, financial pressures in the NHS and local authorities were most commonly cited as barriers to partnership working (Figure A8, p 76). (NB: the survey instrument asked respondents to select up to three options for this question but some respondents chose more than three options. We have displayed all the responses to this question, including where people chose more than three options.)

Figure A8 Main challenges to partnership working

What are the biggest challenges to partnership working in your place?
Respondents were allowed to select more than one option.



Source: Survey by The King's Fund. Survey in the field May–June 2024

Only a small amount of additional information was given in the free-text field for this question:

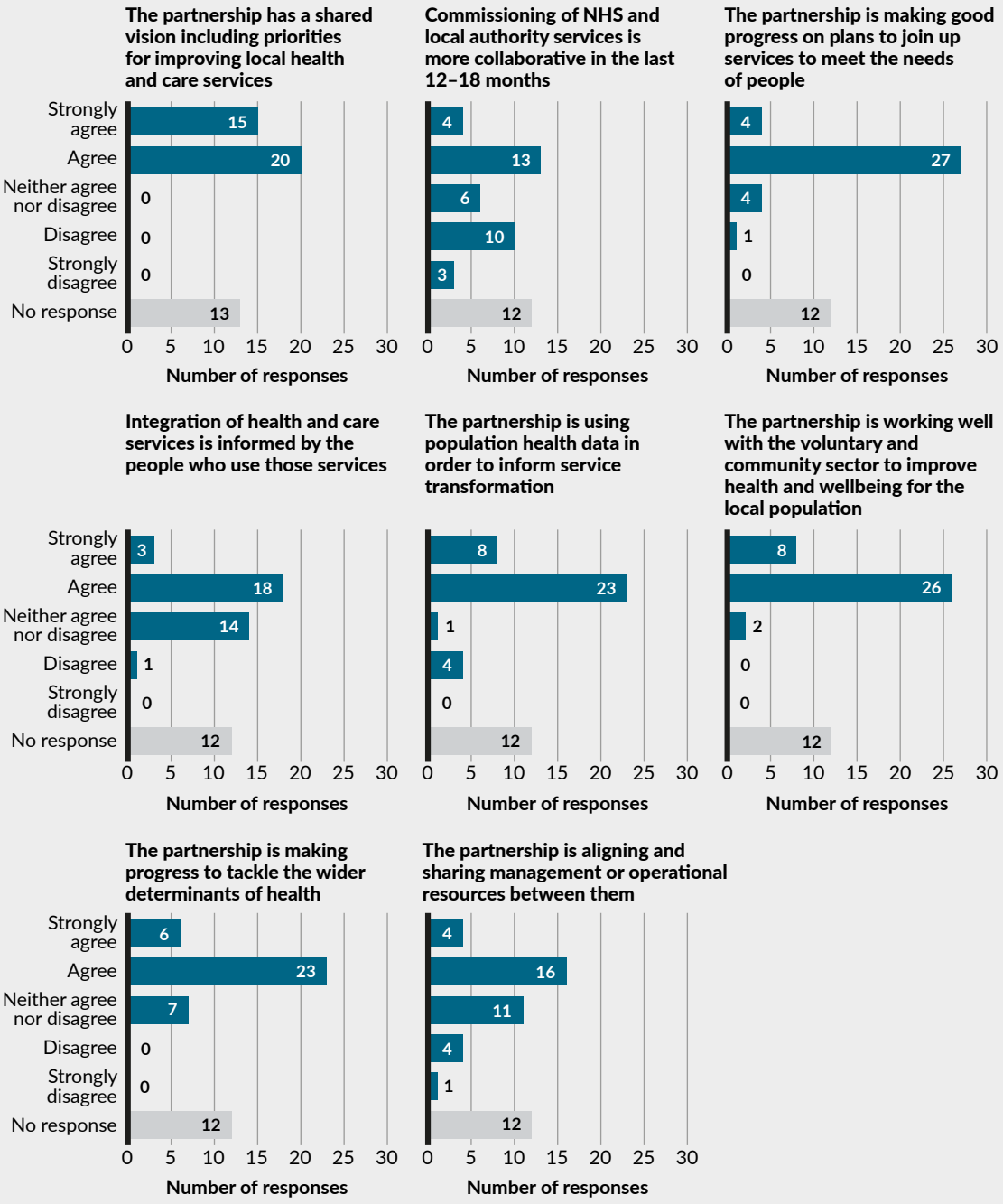
- 'Operational pressures'
- 'There is limited commissioning capacity aligned to place (team is less than 6)'
- 'ICB restructures alongside financial challenges have meant focus has been taken [off] delivery at place at [this] time. However, we have seen this as an opportunity and this has lead [sic] to us developing an integrated place team'

Perceived progress

As discussed in Section 3, survey responses indicate that place-based partnership leaders were fairly positive about progress made towards some of the ambitions set out in *Thriving places* (Figure A9, p 77).

Figure A9 Perceptions about progress of place-based partnerships towards goals and ambitions set out in *Thriving places*

The *Thriving places* guidance suggests place partnerships can be involved in a range of activities. To what extent do you agree or disagree with the following statements?



Source: Survey by The King's Fund. Survey in the field May–June 2024

References

Buck D, Baylis A, Dougall D, Robertson R (2018). *A vision for population health: towards a healthier future*. London: The King's Fund. Available at: www.kingsfund.org.uk/insight-and-analysis/reports/vision-population-health (accessed on 3 February 2025).

Charles A, Ewbank L, Naylor C, Walsh N, Murray R (2021). *Developing place-based partnerships: the foundation of effective integrated care systems*. London: The King's Fund. Available at: www.kingsfund.org.uk/insight-and-analysis/reports/place-based-partnerships-integrated-care-systems (accessed on 13 December 2024).

Checkland K, Bramwell D, Hammond J, Bailey S, Warwick-Giles L, Allen P, Sanderson M (2024). *Effective commissioning for integrated service delivery at place: what functions and structures does the literature suggest are required?* NIHR Policy Research Unit in Health and Social Care Systems and Commissioning. London: NIHR. Available at: https://pru.hssc.ac.uk/assets/uploads/files/commissioning-for-integrated-service-delivery-at-place-initial-report-final-2.pdf (accessed on 5 February 2025).

Department of Health and Social Care (2023a). *Shared outcomes toolkit for integrated care systems*. GOV.UK website. Available at: www.gov.uk/government/publications/shared-outcomes-toolkit-for-integrated-care-systems/shared-outcomes-toolkit-for-integrated-care-systems (accessed on 13 February 2025).

Department of Health and Social Care (2023b). *The Hewitt review: an independent review of integrated care systems*. GOV.UK website. Available at: www.gov.uk/government/publications/the-hewitt-review-an-independent-review-of-integrated-care-systems (accessed on 13 December 2024).

Department of Health and Social Care (2022). *Health and social care integration: joining up care for people, places and populations*. GOV.UK website. Available at: www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations (accessed on 13 December 2024).

Department of Health and Social Care and NHS England (2025). *Reforming elective care for patients*. NHS England website. Available at: www.england.nhs.uk/publication/reforming-elective-care-for-patients/ (accessed on 15 January 2025).

Fenney D, Chikwira L, Chauhan K (2023). 'Transforming power relationships in partnership working'. The King's Fund website. Available at: www.kingsfund.org.uk/insight-and-analysis/long-reads/transforming-power-relationships-partnership-working (accessed on 13 January 2025).

Ham C, Alderwick H (2015). *Place-based systems of care: a way forward for the NHS in England*. London: The King's Fund. Available at: www.kingsfund.org.uk/insight-and-analysis/reports/place-based-systems-care#key-findings (accessed on 2 February 2025).

Hoole C (2024). 'What is place-based partnership working and why is it important?' University of Birmingham Local Policy Innovation Hub Blog. Available at: https://blog.bham.ac.uk/lpip/2024/01/11/what-is-place-based-partnership-working-and-why-is-it-important/ (accessed on 7 February 2025).

Local Government Association (2024). *Effective accountability and assurance of delivery in place-based partnerships*. London: Local Government Association. Available at: www2.local.gov.uk/publications/effective-accountability-and-assurance-delivery-place-based-partnerships (accessed on 4 February 2025).

Ministry of Housing, Communities and Local Government (2024). *English Devolution White Paper*. GOV.UK website. Available at: www.gov.uk/government/publications/english-devolution-white-paper-power-and-partnership-foundations-for-growth/english-devolution-white-paper#facing-the-future (accessed on 4 February 2025).

National Audit Office (2017). *Health and social care integration*. HC 1011 Session 2016–17 8. Available at: www.nao.org.uk/reports/health-and-social-care-integration/ (accessed on 3 February 2025).

Naylor C, Charles A (2022). 'Place-based partnerships explained'. The King's Fund website. Available at: www.kingsfund.org.uk/publications/place-based-partnerships-explained (accessed on 13 December 2024).

Naylor C, Cream J, Chikwira L, Gowar C (2024). *Realising the potential of integrated care systems: developing system-wide solutions to workforce challenges*. London: The King's Fund. Available at: www.kingsfund.org.uk/insight-and-analysis/reports/integrated-care-systems-workforce (accessed on 4 February 2024).

NHS England (2025a). *Neighbourhood health guidelines 2025/26* [online]. Available at: www.england.nhs.uk/long-read/neighbourhood-health-guidelines-2025-26/ (accessed on 4 February 2025).

NHS England (2025b) *2025/26 priorities and operational planning guidance* [online]. Available at: www.england.nhs.uk/publication/2025-26-priorities-and-operational-planning-guidance/ (accessed on 4 February 2025).

NHS England (2023). 'ICB running cost allowances: efficiency requirements'. Letter from NHS England to ICB chief executives, dated 2 March 2023. Available at: www.england.nhs.uk/wp-content/uploads/2023/03/PRN00292-icb-running-cost-allowances-efficiency-requirements.pdf (accessed on 13 December 2024).

NHS England (2022). *What are integrated care systems?* [online]. NHS England. Available at: www.england.nhs.uk/integratedcare/what-is-integrated-care/ (accessed on 17 December 2024).

NHS England and Local Government Association (2021). *Thriving places. Guidance on the development of place-based partnerships as part of statutory integrated care systems. Version 1, September 2021* [online]. Available at: www.england.nhs.uk/publication/integrated-care-systems-guidance/ (accessed on 13 December 2024).

Perrin I, Hunter H, Ruthven C, Clements E, Raine J (2024). *The state of integration at place: exploring how and why place is the 'engine room' of integration* [online]. Available at: www.nhsconfed.org/publications/state-integration-place-neighbourhoods (accessed on 13 December 2024).

Streeting W (2024). *Our ambition to reform the NHS*. Speech by the Health and Social Care Secretary at the NHS Providers annual conference 2024 in Liverpool. Available at: www.gov.uk/government/speeches/our-ambition-to-reform-the-nhs (accessed on 13 December 2024).

Walsh N, de Sarandy S (2023). *The practice of collaborative leadership across health and care services*. London: The King's Fund. Available at: www.kingsfund.org.uk/insight-and-analysis/reports/practice-collaborative-leadership (accessed on 4 February 2025).

Acknowledgements

We would like to thank the survey respondents for providing insight into how place-based partnerships are developing. We are particularly grateful to interviewees in the three case study sites for shining a light on the nature and reality of working at place level – both the rewards and the challenges. We appreciate their generosity in taking the time to speak to us.

At The King's Fund, we would like to thank Alex Baylis, Alison Jury, Clare Sutherland, Funto Akarakiri, Siva Anandaciva and Danielle Jefferies for their support in carrying out the research and analysis. Thanks also to our colleagues in Communications and Engagement.

We also thank colleagues from the policy teams at the Department of Health and Social Care for the information and support they have offered.

Finally, we are grateful to our colleagues Chris Naylor, Anna Charles, Nicola Walsh and Jeremy Cox, as well as Laura Taylor-Green (Director of the North East Essex Alliance) and Sarah Walter (Director of the ICS Network at the NHS Confederation) who reviewed drafts of this report.

About the authors

Shilpa Ross is a Fellow in the Policy team at The King's Fund with a particular interest in workforce, culture and leadership. She works on a range of health and social care research programmes. Most recently, she led The King's Fund's research projects on embedding the voluntary, community and social enterprise (VCSE) sector in integrated care systems (ICSs) and the experiences of directors of public health during Covid-19. Topics of her other recent reports include lessons from the health care response to the Grenfell Tower fire, strategies to reduce waiting times for elective care, workforce race inequalities and inclusion in the NHS, the role of volunteers in the NHS, and transformational change in health and care.

Nicola Blythe is a Researcher in the Policy team at The King's Fund. She is fascinated by the ways in which people and relationships underpin, enable and subvert change in the health and care sector and beyond. Nicola joined The King's Fund from North East London NHS Foundation Trust, where she was an Open Dialogue practitioner and social worker in a community mental health team. It was in supporting the delivery of a clinical trial and roll-out of a new way of working across the service that Nicola gained an appreciation of the necessarily human aspect of facilitating change in systemic structures and processes. Before this, Nicola led on a wide range of research projects (with a particular leaning towards qualitative and ethnographic research) at research consultancy, BritainThinks.

Joni Jabbal is a Senior Researcher in the Policy team at The King's Fund. Joni contributes to the Fund's research and analysis on health and social care policy and practice. Her recent work includes projects on workforce planning, patient experience, digital inclusion in health and care, and health inequalities. Joni has a particular interest in incentives and behavioural outcomes in health care settings. Before joining the Fund in 2013, Joni worked at the Royal College of Physicians, focusing on the impact of NHS reforms, developing new models of urgent and emergency care services, and leading the college's public health work. Joni has an MSc in comparative social policy from the University of Oxford.

CJ Nwasike is a Policy and Research trainee at The King's Fund with interests in patient safety, workforce development and health inequalities. CJ is also a mental health nurse with Derbyshire Healthcare NHS Foundation Trust, and has worked in acute, community and triage settings, where he maintains clinical practice, while contributing to policy and research across various specialisms. Prior to this, CJ was involved in research around workforce development, patient safety, and service improvement and health outcomes at the Royal College of Nursing (RCN), NIHR Health and Social Care Workforce Panel, and University of Staffordshire.

Published by
The King's Fund
11–13 Cavendish Square
London W1G 0AN
Tel: 020 7307 2568

Email:
publications@kingsfund.org.uk

www.kingsfund.org.uk

First published 2025
by The King's Fund

Charity registration number:
1126980

ISBN: 978 1 915303 23 3

A catalogue record for this publication is available from the British Library

Edited by Kathryn O'Neill

Typeset by
Grasshopper Design Company,
www.grasshopperdesign.net

The King's Fund is an independent charity working to improve health and care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible health and care is available to all.

www.kingsfund.org.uk **@thekingsfund**

The King's Fund

Ideas that change health and care

The King's Fund
11–13 Cavendish Square
London W1G 0AN
Tel: 020 7307 2568

Charity registration number: 1126980

www.kingsfund.org.uk

ISBN 978-1-915303-23-3