Further guidance on Integrated Care Systems (ICSs), including place-based partnerships

NHS England and NHS Improvement (NHSE/I) has created a set of resources to help systems prepare to establish statutory ICS arrangements from April 2022. NHSE/I published guidance on provider collaboratives (10 August), as well as several documents setting out the functions and governance of integrated care boards (ICBs) (19 August), which we summarised in this briefing.

On 2 September NHSE/I published several further guidance documents, including Thriving places: guidance on the development of place-based partnerships as part of statutory ICSs and ICS implementation guidance on partnerships with the voluntary, community and social enterprise (VCSE) sector, effective clinical and care professional leadership, and working with people and communities. This briefing summarises these resources and sets out our initial analysis of the implications for trusts. Please contact senior policy manager Georgia Butterworth (georgia.butterworth@nhsproviders.org) if you have any comments or questions.

Key points

- The Thriving places guidance aims to support all partners working in ICSs to collectively define and evolve their place-based working arrangements, activities and governance.
  - It positions places as the foundations of ICSs and sets out the activities that place-based partnerships may lead, including coordinating the planning and delivery of integrated services.
  - It guides partners to agree a shared vision at place level, identify their purpose and role in the system, and collaboratively define their geographic footprint.
  - It also proposes several potential governance arrangements following the passage of legislation, including consultative forums, joint committees and lead provider models. These arrangements should be determined by local partners, so will vary across the country.
  - ICBs, NHS providers or local government may delegate statutory functions and budgets to place-based partnerships, but will retain accountability for these functions.
  - ICS leaders are expected to confirm initial proposals for place-based partnership arrangements in their system for 2022/23 as part of their ICS development work in 2021/22.
  - Place-based partnerships will have a role in developing the integrated care partnership's (ICP's) integrated care strategy and the ICB's NHS plan. They will also work with provider collaboratives to ensure they meet population needs without duplication.

- The **implementation guidance on partnerships with the VCSE sector** aims to support systems to embed VCSE partnership in the ICS.
  - It also sets out the key actions that are required of ICSs. By April 2022, ICBs are expected to have developed a formal agreement for engaging and embedding the VCSE sector in system-level governance and decision-making arrangements, ideally through a VCSE alliance.
  - NHSE/I states that these arrangements should build on the involvement of VCSE partners in relevant forums at place and neighbourhood level.
- NHSE/I has also published **guidance to support the development of distributed clinical and care professional leadership across ICSs**, and ensure these leaders are integrated into decision-making.
  - NHSE/I expects system leaders to agree a local framework and associated development plan for clinical and care professional leadership with partners across the ICS.
  - The nursing director and medical director on the board of the ICB should ensure leaders from all clinical and care professions are involved and invested in the work of the ICS.
  - The guidance identifies five core design principles and "what good looks like" criteria, which ICSs can use to guide the development of their locally determined arrangements.
  - Targeted improvement funding will be allocated to systems in the second half of 2021/22 to support implementation.
- The implementation **guidance on working with people and communities** sets out principles, core requirements and good practice to support ICSs to listen and act on the experience and aspirations of local people and communities.
  - It sets out key actions ICSs must take, including: developing a system-wide strategy by April 2022; setting out arrangements for engagement in ICB constitutions; and ensuring that ICPs and place-based partnerships have representation from people and communities in key forums.
- We welcomed the opportunity to contribute to the development of these guidance documents and feed in the views of trust leaders, and look forward to continuing to work closely with NHSE/I.

Thriving places: guidance on the development of place-based partnerships as part of statutory ICSs

NHSE/I has co-produced guidance with the Local Government Association to support all partner organisations working in ICSs to collectively define their place-based partnerships, and to consider how they will evolve to support the transition to new statutory ICS arrangements. NHSE/I has also published learning from place-based partnerships.

NHSE/I positions place-based partnerships as the foundations of ICSs, and defines them as "collaborative arrangements formed by the organisations responsible for arranging and delivering

health and care services in a locality or community". They involve the NHS, local government and providers of health and care services, including the VCSE sector, people and communities. NHSE/I expects place-based partnerships to build and maintain broader coalitions with wider community partners to influence the wider determinants of health.

ICS leaders are expected to confirm initial proposals for place-based partnership arrangements in their system for 2022/23 as part of their ICS development work during 2021/22. These proposals should be mutually agreed by system partners and should set out boundaries, system responsibilities and functions conducted at place level, and the planned governance model.

The guidance document makes a distinction between the role of "at scale provider collaboratives" – bringing together providers across multiple places to deliver benefits of mutual aid and working at scale – and place-based partnerships coordinating the planning and delivery of integrated services within localities. NHSE/I recognises that some providers will be members of both provider collaboratives and place-based partnerships, and advises they should work to ensure their role in the partnership is clearly defined and to avoid duplication or conflict with collaborative arrangements.

Defining place within the health and care system

Place based partnerships have been asked to collaboratively define their geographic footprint, which should be meaningful to local people and have a coherent identity. The guidance encourages partners to consider where local government services are planned and what that means for joint working opportunities at different parts of the system. It also encourages partners to consider how NHS services are organised and how local people use NHS services. The guidance also highlights other contextual factors for partners to consider when defining place, including health and wellbeing board (HWB) footprints, existing partnerships, and geographical features.

The guidance therefore provides flexibility for system partners to build on existing arrangements and agree the boundaries, functions and activities of places at local level. For example, in some systems place and system will be coterminous. NHSE/I and the LGA therefore set out guiding principles for partners at place to consider, such as agreeing a shared purpose before defining structures.

Defining the purpose and role of the place-based partnership

NHSE/I expects partners at place to agree a shared vision and objectives, and use these to define the purpose and role of the partnership (which may include the statutory functions delivered by the

bodies in the partnership). The vision for places should focus on improving health and wellbeing outcomes for the population, preventing ill health and addressing health inequalities. The objectives may relate to improving quality and accessibility of services.

Potential activities of place-based partnerships include (not an exhaustive list): health and care strategy and planning at place; service planning (including aligning commissioning of NHS and local government services); delivery and transformation; and population health management. These may be underpinned by shared capabilities, such as people and analytics functions, and may be led by individual organisations or resourced collaboratively by programmes delivered across organisational boundaries.

Place-based partnerships should work with other partners across the ICS to agree the activities and capabilities that may be most effectively delivered at scale across the system, or where a consistent approach across places is appropriate. As part of this, the partnership will have a role to agree the shared priorities of the wider system, which will include working with provider collaboratives to ensure this meets the needs of communities in their place, and to avoid duplication of activities. Places will also have a role in informing and developing the integrated care strategy agreed by all partners in the ICP, and the NHS plan developed by the ICB.

Governance, decision-making and accountability

The NHS, local government and other local partners - including the ICP - should agree the planned governance model for place, including: membership, decision-making arrangements, leadership roles and representation on/reporting relationships with the ICP and ICB.

Membership

The guidance advises considering representation from: primary care; providers of acute, community and mental health services; people who use care and support services and their representatives; local authorities; social care providers; the VCSE sector; and the ICB. Other community partners may be involved in the partnership, as members of committees or through other working groups and arrangements. This will depend on the objectives of the partnership, and may include housing associations and education providers. Partners will need to agree how those with more complex footprints, such as ambulance trusts, may be most appropriately represented.

Governance, decision-making arrangements and accountabilities

Governance arrangements, and the allocation of decision-making responsibilities between system and place, will vary across the country.

NHSE/I proposes the following governance arrangements could be established at place (if the Bill is passed in its current form):

- A consultative forum to inform and align decisions by relevant statutory bodies in an advisory role
- Individual executives/staff exercising delegated functions and convening a committee to support them
- A committee of a statutory body with delegated authority to make decisions and a delegated budget
- A joint committee established between partner organisations with delegated decision-making functions and budget
- A lead provider manages resources and delivery as part of a provider partnership under a contract with the ICB and/or local government

Some of these arrangements must be established independently, while others may be implemented through existing arrangements, such as HWBs. Partners should consider how they will ensure governance and decision-making remains clear and proportionate and avoids duplication across the ICS. They should also have agreed ways of managing disagreement. ICPs should consider how they support place-based partnerships and ensure appropriate resource, capability and delegated decision-making are established at place.

ICBs, NHS providers or local government may delegate statutory functions to place-based partnerships, but will retain accountability for these functions. Statutory bodies may set a budget for place-based partnerships, where decision-making functions are delegated to the partnership.

Place-based partnerships should agree the arrangements required to fulfil the NHS, local government and other organisations' accountabilities appropriately. Following the NHS system oversight framework publication, places and ICB leadership should consider and define the role that places will play in monitoring performance.

Leadership

NHSE/I envisages a range of leadership roles at place, depending on the partnership's responsibilities, and sets out key leadership skills and behaviours. These roles will typically fall into three categories: partnership convenors, executive leads and programme leads. NHSE/I recognises that many place

leaders will balance multiple roles in the system, so there must be an agreed process to managing any potential conflicts of interest.

NHS Providers view

The ICS design framework set out NHSE/I's ambition to create a flexible operating model for ICSs from April 2022, and clear next steps for NHS organisations to take during this transition year. We welcome the flexibility of the place partnerships guidance, which should support trusts and their partners to continue developing arrangements at place that suit their local populations and circumstances. This bottom-up approach to designing system working is crucial for its success, given the variation in size, geography and provider landscape within ICSs.

We also welcome NHSE/I's recognition of the contribution of all trust types at place level. Previous guidance documents (e.g. Integrating Care) focused on the role of community and mental health provision at place level, rather than acknowledging the important role played by local acute services. It is also encouraging to see NHSE/I recognising that for providers working across multiple ICSs, such as ambulance trusts, engaging at place level presents a particular set of challenges.

However, we do have concerns about some of the specific elements of the guidance. Firstly, it positions place-based partnerships as primarily collaborations between "the organisations responsible for arranging and delivering health and care services in a locality". Only then does it acknowledge the importance of building "broader coalitions" with wider community partners to promote health and wellbeing, such as housing associations and education providers. This narrow focus risks undermining the fact that some place partnerships already have a much wider membership, remit and ambition to improve population health and tackle health inequalities, and could risk unintentionally disrupting current arrangements.

Secondly, there must be clarity around what the place-based partnership is accountable for and to whom. This is particularly important if place partnerships have a role in monitoring performance. The guidance also states that partnerships will need to work out reporting relationships with the ICB and ICP. Trust leaders are keen to ensure this does not add duplication or burden. It is also essential to avoid duplication between trusts' and place-based partnerships' accountabilities, especially if ICBs delegate decision-making and budgets to places. What will accountability for funding and delivery at place look like in practice? Non-executive challenge and scrutiny of decision-making at place level will be crucial.

We are pleased to see that the boundaries, membership and functions of place-based partnerships will be locally determined. While it makes sense in some areas to align with where adult social care and public health responsibilities are planned across local authority footprints, the idea of neat boundaries in ICSs is a red herring, as patients and service users flow in different ways across geographical areas. Any boundary changes need to be considered as part of a fully transparent process which involves all system partners.

Finally, the inter-relation between places and provider collaboratives is an important consideration. Some trust leaders are concerned this relationship is being defined as linear and hierarchical when it is much more complex and multifactorial. For example, some place-based partnerships see themselves as recommending what provider collaboratives should deliver at scale, and some provider collaboratives see themselves as setting standardised service offers for places to decide how to implement. This complexity could introduce tensions into the system if functions/resources are delegated to both from the ICS. We urge NHSE/I to clarify how they will support systems to navigate these dynamics, and look forward to continuing to work closely with NHSE/I on the development of place partnerships.

2. ICS Implementation guidance on partnerships with the VCSE sector

This guidance builds on the expectation, originally outlined in the ICS design framework, that ICB governance and decision-making arrangements will support close working with the VCSE sector as a strategic partner. NHSE/I provides more guidance on how to embed VCSE sector partnerships in ICSs, although the detail of these arrangements will depend on existing local infrastructure and approaches. There is a national ICS and VCSE sector partnership programme to support this work.

NHSE/I sets two core requirements for ICSs, followed by some examples of good practice:

- By April 2022, ICPs and ICBs are expected to have developed a formal agreement for engaging and embedding the VCSE sector in system-level governance and decision-making arrangements, ideally by working through a VCSE alliance.
- NHSE/I states that these arrangements should build on the involvement of VCSE partners in relevant forums at place and neighbourhood level.

Working with the VCSE sector across the ICS

VCSE sector alliance model

The guidance provides a diagram that shows how a VCSE leadership group/alliance at system level could feed into strategic decision-making. NHSE/I is working with national VCSE partners on a development programme that supports partnership working between ICSs and the VCSE sector.

VCSE partnerships at place

The guidance explains that 'places' tend to be where most voluntary sector funding is allocated (usually by local council area) as well as being the area where the sector can be increasingly embedded in decision-making and strategic planning. NHSE/I expects the VCSE sector will be an integral part of place-based partnerships. This can build on existing structures and networks such as VCSE representation in health and wellbeing boards and local VCSE infrastructure organisations.

VCSE partnerships at neighbourhood

The guidance encourages ICSs to consider how VCSE organisations can be included in multidisciplinary neighbourhood teams along with statutory partners, to improve the support to high-risk and high-intensity service users, as well as considering the importance of social prescribing link workers.

Provider collaboratives and the VCSE sector

Trusts and provider collaboratives commission services from the VCSE sector as part of wider care pathways. NHSE/I expects provider collaboratives will continue to use the expertise of VCSE organisations to support co-design and delivery of health and care services.

NHS Providers view

Given the vital role the VCSE sector plays in the health and care system, NHS Providers welcomes the focus of this guidance document and supports the flexible approach that NHSE/I has taken in allowing ICSs to determine the right partnership arrangements with the VCSE sector locally. While the good practice examples are helpful, systems could benefit from further examples that highlight how ICSs can use and value the VCSE sector at a strategic level.

While it is true that the scale and complexity of voluntary sector organisations can be challenging for trusts and system partners to engage with, the VCSE sector needs to be recognised and celebrated in its diversity, rather than treated as a homogeneous whole. While VCSE alliances can help ensure the sector has a voice at place and system level, innovation is often driven by smaller scale organisations and we need to ensure their ideas feed into system plans and decision-making (perhaps via place-based partnerships, provider collaboratives or trusts as commissioners).

NHSE/I recognises the challenges faced by the VCSE sector in terms of having at scale representation to input into the ICS 'at all levels' (as the guidance suggests), with insufficient funding for representative infrastructure often cited as a barrier. Questions therefore remain around what the advice would be for those VCSE organisations that do not have representation and how they will be able to effectively engage with systems to deliver the key aims.

However, the biggest challenge for the VCSE sector is funding, given the adverse impacts of the pandemic on fundraising. Now more than ever communities and the health and care system need a robust VCSE sector to support people's health and wellbeing. Without sufficient funding, the benefits of prevention, early intervention and community support will not be realised.

3. Building strong ICSs everywhere: ICS implementation guidance on effective clinical and care professional leadership

NHSE/I has also published guidance to support the development of distributed clinical and care professional leadership across ICSs. It aims to ensure clinical and care professional leaders, from a diversity of backgrounds, are integrated into decision-making in a fully inclusive way. The guidance offers a framework on which systems can base their arrangements, while retaining flexibility for local innovation and adoption. NHSE/I does not intend to restrict or prescribe how systems should develop their arrangements, but does expect them to build on the existing clinical and care professional networks such as cancer alliances.

The guidance describes two core expectations for ICSs:

1. Each ICB is expected to agree a local framework for clinical and care professional leadership with ICS partners that demonstrates how they will be involved in decision-making, building on and aggregating neighbourhood and place level arrangements. This framework should make clear how appropriate and equal professional representation will be achieved and how the leadership community will reflect the diversity of the communities served.

2. Individuals in clinical and/or care professional roles on the board of the ICB, including the nursing director and medical director, should ensure leaders from all clinical and care professions are involved and invested in the vision, purpose and work of the ICS.

The guidance also sets out five principles that ICBs should consider when developing distributed models of clinical and care professional leadership in systems. Alongside these principles, the guidance describes "what good looks like" to help systems evaluate current arrangements and identify development needs.

The five principles are:

1. Integrating clinical and care professionals in decision-making at every level of the ICS;
2. Creating a culture of shared learning, collaboration and innovation, working alongside partners and local communities;
3. Ensuring clinical and care professional leaders have appropriate resources to carry out their system role(s);
4. Providing dedicated leadership development for all clinical and care professional leaders; and
5. Identifying, recruiting and creating a pipeline of clinical and care professional leaders.

NHSE/I encourages systems to systematically assess current arrangements against the core requirements and 'what good looks like' criteria. NHSE/I will support systems to implement this guidance, including with some improvement funding for 2021/22. NHSE/I anticipates this funding could be used, for example, to design and deliver a system leadership development offer.

NHS Providers view

We welcome the focus of this guidance document on ensuring that the full range of clinical and care professional leaders, from a diversity of backgrounds, are involved in decision-making throughout the ICS. Having clinical expertise front and centre of the ICB and wider system governance arrangements will be crucial in delivering better integrated care that meets the needs of local populations. Clinical leaders bring valuable clinical expertise to decisions, such as redesigning and transforming services, but they are also skilled system leaders in their own right. We would therefore recommend the ICB, as a unitary board, should hold collective responsibility for ensuring all professions are involved and invested in the ICS's vision (rather than just the medical director and nursing director).

We continue to support NHSE/I's approach to creating an enabling, rather than a prescriptive, framework. This will allow systems to define what a clinically-led ICS looks like in their specific footprint. The five principles and 'what good looks like' criteria provide a tangible way forward for systems to build on existing arrangements.

Ensuring clinicians and care professionals have sufficient time and supporting infrastructure to carry out their system roles meaningfully will be crucial. We welcome NHSE/I's recognition that systems should avoid duplicating existing clinical and care professional network arrangements, when

embedding a clinical voice at all levels of the system. The seed funding for 2021/22 will be vital to help train individuals to take on these new roles. Ensuring a pipeline of leaders with the right skills and improvement knowledge to serve the ICB and its constituent organisations will be key on an ongoing basis. Systems will need sufficient system leadership development budgets, and a rigorous focus on building a diverse and inclusive leadership community.

4. ICS implementation guidance on working with people and communities

NHSE/I has published implementation guidance to support system partners to listen and act on the experience and aspirations of local people and communities. NHSE/I expects ICSs will have legal duties to involve patients and the public, similar to those which currently apply to CCGs.

The ICS design framework set out seven principles for ICSs to consider when developing their approach to working with people and communities. NHSE/I has added three additional principles to the original list of seven, which are:

- Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS
- Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions
- Learn from what works and build on the assets of all ICS partners

Core requirements and good practice

The guidance then sets out core requirements and good practice for how these principles should be applied. All ICBs are expected to develop a system-wide strategy for engaging with people and communities by April 2022, using the ten principles as a starting point. The strategy should describe: the ICB's principles and methods for working with people and communities; its approach to ensuring ICPs and place-based partnerships have representation from local people and communities in decision-making; and the ICB's arrangements for gathering intelligence. ICB constitutions are expected to include principles and arrangements for how the ICB will work with people and communities.

NHSE/I also provides a list of considerations for how leaders may think about involving people and communities, including (not an exhaustive list):

- Devising a clear plan for how system partners work together to engage people and communities;
- Working through non-executive directors, and foundation trust governors and elected members as key partners in connecting to communities;
- Supporting partnerships and primary care networks to work with people and communities to strengthen health prevention and treatment.

Involving people and communities in ICS governance

The guidance discusses the way in which people and communities should be involved in ICS governance and decision-making, suggesting that ICSs should consider several further principles (for example, defining the role and accountability of members of the public in governance structures). Co-production is one of the key ways in which ICSs can work with people and communities. NHSE/I suggests key considerations for specific parts of the ICS, including examples of best practice:

ICP	The ICP should adopt clear and transparent mechanisms for developing integrated care strategies with people and communities. It should meet in public with minutes and papers online. It is expected that Healthwatch will be involved in the ICP.
ICB	Non-executive members will help ensure the statutory duties of the ICB are met, including those relating to patient and public participation. The ICB constitution should include information on how it intends to involve people and communities. The ICB is expected to adopt clear and transparent mechanisms for developing plans.
Place-based partnerships	These partnerships should include representation from people and communities, building on existing engagement approaches. They should consider how to support co-production and transparency.
System quality groups	These groups will be responsible for quality governance and oversight across systems, and should include at least two lay members.
Public engagement groups	These groups may include: patient and public reference groups, citizens' panels, forums to engage with specific equalities protected groups, and expert by experience and VCSE members of programme boards for specific workstreams

It is expected that legislation will change the existing statutory duties of local Healthwatch to advise and inform CCGs so that they apply to ICSs. NHSE/I encourages all ICSs to talk to Healthwatch about arrangements at both system and place level.

Working with people and communities to tackle health inequalities

The guidance highlights the impact of COVID-19 as giving fresh momentum to tackling health inequalities and makes clear the importance of engaging with local populations and communities to help narrow the health inequalities gap. ICS partners should take particular care to hear from people who cannot access care and support to understand their needs, barriers, aspirations and opportunities for improvement. Some practical steps to achieve this include (not an exhaustive list):

- Prioritising building relationships with people who are excluded from services;
- Taking the opportunities presented by collaboration in the ICS to mobilise the strengths and experience of all partners; and
- Using population health management approaches to better understand populations needs.

NHS Providers view

This guidance helpfully emphasises the importance of decision-making at all levels of the system taking into account people's needs, experience and aspirations, as this will lead to better designed services to meet their needs. Ensuring engagement is coordinated across partners and builds on what is already working well at system, place and neighbourhood level is key to avoiding duplication. For example, we were pleased to see the role of non-executive directors and foundation trust governors referenced as an important means of connecting to communities.

We welcome the flexibility afforded in NHSE/I's approach, which includes some helpful principles and practical next steps, and will seek clarification on whether (and if so, how) ICSs' locally determined engagement arrangements will be assessed in future. Communities also play an important role in improving health and wellbeing. ICSs therefore not only need to consider how to involve people and communities in their governance structure, but also enable communities to improve and sustain good health and wellbeing. In some systems, it would make sense for this focus to be at place and neighbourhood level, where links to people and communities are strongest, rather than at ICS level.