Options for governance and management arrangements for place-based partnerships in Lancashire and South Cumbria (LSC)

Engagement within place-based partnerships

1. Introduction

1.1. The Integrated Care Systems: design framework was published by NHS England in June 2021. The guidance sets out five place-based governance arrangements that could be established by the NHS ICS body in partnership with local authorities and other partners to jointly drive and oversee local integration.

1.2. This paper provides a number of principles that describe our intended ways of working as five place-based partnerships supported and enabled by the LSC system, based on the content of our common strategic narrative and our partnership agreements. It then considers the five place-based governance arrangements against these principles.

1.3. A number of questions are posed, which the ICP Development Advisory Group would like each of the place-based partnerships to consider before reviewing this feedback at its meeting in September 2021.

2. National context – the Integrated Care Systems: design framework

2.1. The Integrated Care Systems: design framework was published by NHS England in June 2021. The document begins to describe future ambitions for:

- The functions of the ICS Partnership (in LSC we refer to the Health and Care Partnership)
- The functions of the ICS NHS body
- The governance and management arrangements that each ICS NHS body will need to establish
- The opportunity for partner organisations to work together as part of ICSs
- Key elements of good practice that will be essential to the success of ICSs
- The key features of a financial framework
- The roadmap to implement new arrangements for ICS NHS bodies by April 2022

2.2. The document contains a section on Governance and management arrangements, and within this section there is specific reference to place-based partnerships (see Appendix A for full text from this section of the document). It sets out five place-based governance arrangements that could be established by the NHS ICS body in partnership with local authorities and other partners to jointly drive and oversee local integration. These are:

- A consultative forum, informing decisions by the ICS NHS body, local authorities and other partners
- A committee of the ICS NHS body with delegated authority to take decisions about the use of ICS NHS body resources
- Joint committee of the ICS NHS body and one or more statutory provider(s)
- Individual directors of the ICS NHS body having delegated authority, which they may choose to exercise through a committee.
- A lead provider managing resources and delivery at place-level under a contract with the ICS NHS body

2.3. There is no stipulation within the guidance as to which model is preferred; indeed, it is indicated that the ICS NHS Body, working with partners, should determine the best approach for its places.

2.4. Colleagues from NHSEI have confirmed that a combination of these arrangements can be used to support place-based partnerships to operate effectively within the wider system partnership.

2.5. Whilst further national guidance is anticipated in early September in relation to the development of place-based partnerships, this will be in the form of "guidance on effective partnership working", not specific "must do's". Therefore, this additional guidance can be considered as part of the engagement process set out in section 8.

3. Lancashire and South Cumbria context – the common ICP strategic narrative

3.1. In our common ICP strategic narrative, agreed by the ICS Board in December 2020, we set out what we mean by an 'Integrated Care Partnership':

> *"An Integrated Care Partnership (ICP) is a collaboration of planners and providers across health, local authority and the wider community, who take collective responsibility for improving the health and wellbeing of residents within a place, with a population of up to 500,000. Most people's day to day care and support needs will be met within a place and delivered in neighbourhoods of 30,000 to 50,000 people"*

3.2. We also described the common purpose of an ICP as:

> *"…to enable collaboration that will address specific place-based challenges and deliver within each place the component parts of the Integrated Care System (ICS) strategy"*

3.3. The strategic narrative references the allocation of resources, collective decision-making, and accountability:

> *"In the future, it is expected that the NHS will move towards organisations within each ICP receiving a financial allocation for the place, based on capitation; the principle that money is allocated per person in each place.*
>
> *"This, along with the potential for increased use of pooled budgets, will mean that partners within the ICP will make collective decisions on how best to invest financial resources in order to deliver neighbourhood-based, place-based, regional and national requirements and ambitions across health, care and wellbeing. Partners will need to be clear on their own role in delivery and will need to hold each other to account to ensure collective achievement of their place-based objectives."*

4. Lancashire and South Cumbria context – our partnership agreements

4.1. As part of the collective ICP development programme, the partners in each place have committed to a Partnership Agreement, the core content of which is common across all five ICPs.

4.2. Part of this core content references principles of working together, which include the following:

- Put our residents at the heart of what we do
- Address inequalities
- Be good partners to each other
- Adhere to our agreements and hold each other to account

- Implement a distributed leadership model
- Recognise our role in the wider Lancashire and South Cumbria system

5. Our intended ways of working – key principles

5.1. Using sections 3 and 4 above, we have proposed a small number of key principles to describe our intended ways of working as five place-based partnerships supported and enabled by the LSC system. These are:

5.1.1. There should be **collective ownership and accountability** at place for:

- Improving the health and wellbeing of our residents
- Planning and delivering safe and effective services that meet the needs of our residents
- Managing resources effectively

5.1.2. There should be **collective decision-making** at place when:

- Agreeing priorities
- Allocating and managing resources

5.1.3. Places should feel **empowered to act** in the best interests of their residents, whilst recognising their role as part of a wider system. This will require **clear assurance processes**:

- Between the partners within the place
- Between the place and the community which it serves
- Between each place and the system

6. Consideration of options for place-based partnerships within Lancashire and South Cumbria (LSC)

6.1. A review of the various options set out in the Integrated Care Systems: design framework is summarised in Appendix B, with key features, benefits and risks identified. It should be noted that these are mainly extracted from work undertaken outside of the LSC system.

6.2. However, each of the options has also been considered against the three key principles outlined in section 5, with a summary rating used to indicate the **suggested** overall ability of the option to meet the three key principles:

HIGH	Strong ability to meet the principle
MEDIUM	Some ability to meet the principle
LOW	Weak ability to meet the principle

6.3. It must be noted that in this exercise, the description of a “consultative forum” as set out in the national publication is somewhat unambitious. In discussion with NHSEI colleagues and across our place-based partnerships, we have adopted a more ambitious approach to what this could offer. We envisage this working as a place-based partnership board where every partner has delegated decision making from their organisation through the individuals who are members of the board. It is therefore intended to be much more than purely “consultative”.

	Option 1 Consultative Forum	Option 2 Committee of ICS NHS Body	Option 3 Joint committee	Option 4 Delegated authority to individual director	Option 5 Lead provider contract
Description	In LSC, we envisage this working as a **place-based partnership board where every partner has delegated decision making** from their organisation through the individuals who are members of the board. *Option closest to current ways of working.*	A committee of the ICS NHS body with delegated authority to take decisions about the use of ICS NHS body resources	The ICS NHS body with one or more statutory bodies would delegate decision making on specific functions/services/ populations to the specified joint committee in accordance with their schemes of delegation *Likely to be a complex/time-consuming model to agree across multiple statutory partners.*	An individual director would have delegated authority from the ICS NHS Body around the L&SC NHS budget that is allocated to place. Delegations would be set out in the organisation's scheme of delegation. *Most likely to operate in combination with another option*	Lead provider holds the contract with the ICS NHS Body and has lead responsibility for delivering the agreed outcomes for the place
Potential combinations	Could operate in conjunction with: Option 4	Could operate in conjunction with: Option 3 and/or 4	Could operate in conjunction with: Option 2 and/or 4	Could operate in conjunction with: Option 1, 2, or 3	Could operate in conjunction with: N/A
Key	**HIGH:** Strong ability to meet the principle		**MEDIUM:** Some ability to meet the principle	**LOW:** Weak ability to meet the principle	
Collective ownership and accountability for: • Improving health & wellbeing of residents • Planning & delivering safe and effective services that meet needs of residents • Managing resources effectively	**Suggested ability: LOW / MEDIUM** *(depending on strength of partnership)* No formal delegated authority or accountability to the place-based partnership board. Therefore, not clear where NHS body resources or accountability would be delegated to if this is selected as a standalone option. Collective ownership and accountability would rely on relationships between partners and a robust partnership agreement. If this isn't constituted properly, it would operate as a consultative forum – needs explicit clarity on decision-making though individuals. **If selected with option 4,** could be constructed in a way where accountability and decision-making sits with this board where items exceed the limits of the individual director. **Suggested ability: MEDIUM**	**Suggested ability: MEDIUM / HIGH** *(depending on composition of Committee and ToRs)* Formal delegated authority and accountability to the place-based committee of the ICS NHS body, which therefore has collective ownership and accountability across its members, and clear accountability to the ICS NHS Body. Significant work required to determine delegations to the committee and the role of partners within the committee. Risk that this is perceived as an NHS-only or NHS-driven group, as it is a committee of an NHS body. Good governance would suggest a non-executive chair. **If selected with option 4**, could be constructed in a way where accountability sits with the place-based committee of the ICS NHS body where items exceed the limits of the individual director. **Suggested ability: MEDIUM / HIGH** *(depending on delegations and ToRs)*	**Suggested ability: MEDIUM / HIGH** *(depending on composition of Committee and ToRs)* Formal delegated authority and accountability to the place-based joint committee of the statutory partners, which therefore has collective ownership and accountability across its members, and accountability to all of its statutory organisations who have delegated accountability and decision-making. Requires formation of a joint committee across ICS NHS body and statutory partners in each place (e.g. Trusts, Local Authorities). Risk that this is perceived as excluding key partners such as primary care, VCFSE. Significant work required to determine delegations to the committee and the role of partners within the committee. This would apply not just to the NHS ICS body but also across all relevant statutory partner organisations which form the joint committee. Good governance would suggest a non-executive chair. **If selected with option 4**, could be constructed in a way where accountability sits with the place-based joint committee of the statutory partners where items exceed the limits of the individual director. **Suggested ability: MEDIUM / HIGH** *(depending on delegations and ToRs)*	**Suggested ability: LOW** *(as a standalone option)* Formal delegated authority and accountability to the individual director of the ICS NHS body. Therefore, no collective ownership or accountability if selected as a standalone option. **If selected with option 1**, could be a requirement for collective ownership across the place-based partnership through a robust partnership agreement. **Suggested ability: LOW / MEDIUM** *(depending on delegations and strength of partnership)* **If selected with options 2 or 3**, could be constructed in a way where accountability sits with the place-based committee of the ICS NHS body or the place-based joint committee of the statutory partners where items exceed the limits of the individual director. **Suggested ability: MEDIUM / HIGH** *(depending on delegations and ToRs)*	**Suggested ability: LOW / MEDIUM** *(depending on ways of working of lead provider)* Formal delegated authority and accountability to the lead provider. Lead providers will need to be statutory organisations. Risk that this becomes part of the lead provider organisational arrangements and does not adequately involve wider partners. Any collective ownership and accountability would rely on relationships between partners and a robust partnership agreement.
Collective decision-making at place when: • Agreeing priorities • Allocating & managing resources	**Suggested ability: LOW / MEDIUM** *(depending on strength of partnership)* No formal delegated decision-making to the place-based partnership board. Collective decision-making would rely on relationships between partners and a robust partnership agreement.	**Suggested ability: MEDIUM / HIGH** *(depending on composition of Committee and ToRs)* Formal delegated decision-making to the place-based committee of the ICS NHS body. Collective decision-making would rely on relationships between partners and robust ToRs to ensure partners have an equal voice	**Suggested ability: MEDIUM / HIGH** *(depending on composition of Committee and ToRs)* Formal delegated decision-making to the place-based joint committee of the statutory partners. Collective decision-making would rely on relationships between partners and robust ToRs to ensure partners have an equal voice	**Suggested ability: LOW** *(as a standalone option)* Formal delegated decision-making to the individual director of the ICS NHS body. Therefore, no collective decision-making if selected as a standalone option, except through engagement of the individual director with other partners.	**Suggested ability: LOW / MEDIUM** *(depending on ways of working of lead provider)* Formal delegated decision-making to the lead provider. Lead providers will need to be statutory organisations.

	Ability to make decisions is through its members, who will act based upon the Scheme of Reservation and Delegation (SORD) of their own organisation. Where decisions exceed the limits of SORDs for these individuals, decision will need to be taken back into individual organisations to be made via organisational governance routes. Further consideration required in relation to how this will work for key partners such as primary care, VCFSE. Not able to hold budgets directly, therefore mechanisms for this need further consideration if this is selected as a standalone option. **If selected with option 4**, could be constructed in a way where accountability and decision-making sits with the place-based partnership board where items exceed the limits of the individual director. **Suggested ability:** MEDIUM	and that one partner is not able to veto decisions. Risk that this is perceived as an NHS-only or NHS-driven group, as it is a committee of an NHS body. By selecting this as a standalone option, this could result in all decisions needing to be made by the committee, regardless of the scale of impact on residents/patients and/or financial value. **If selected with option 4**, could be constructed in a way where accountability and decision-making sits with the place-based committee of the ICS NHS body where items exceed the limits of the individual director. **Suggested ability:** MEDIUM / HIGH *(depending on delegations and ToRs)*	and that one partner is not able to veto decisions. Risk that this is perceived as a statutory body driven group, as it is a committee of statutory organisations. By selecting as a standalone option, this could result in all decisions needing to be made by the committee, regardless of their impact on residents/patients and/or financial value. **If selected with option 4**, could be constructed in a way where accountability and decision-making sits with the place-based joint committee of the statutory partners where items exceed the limits of the individual director. **Suggested ability:** MEDIUM / HIGH *(depending on delegations and ToRs)*	**If selected with option 1**, could be a requirement for collective decision-making across the place-based partnership through a robust partnership agreement. **Suggested ability:** LOW / MEDIUM *(depending on strength of partnership)* **If selected with options 2 or 3**, could be constructed in a way where accountability sits with the place-based committee of the ICS NHS body or the place-based joint committee of the statutory partners where items exceed the limits of the individual director. This could also address the risk of all decisions needing to be made by the committee, regardless of their impact on residents/patients and/or financial value. **Suggested ability:** MEDIUM / HIGH *(depending on delegations and ToRs)*	Risk that this becomes part of the lead provider organisational arrangements and does not adequately involve wider partners. Any collective decision-making would rely on relationships between partners and a robust partnership agreement.
Empowered to act in best interests of residents, whilst recognising role as part of wider system. Will require **clear assurance processes**: • Between partners within place • Between place and community • Between place and system	**Suggested ability:** LOW / MEDIUM *(depending on strength of partnership)* No formal delegated authority to the place-based partnership board. Therefore, it is not clear how places are truly empowered to act if this is selected as a standalone option. Assurances between partners in the place would rely on relationships between partners and a robust partnership agreement. Assurances to the community would be determined by each place. Could be addressed through board membership or by meeting in public. Assurances to the system would be via reporting to the system, but with no formal delegated authority or accountability, this could prove challenging. Could be managed via an MoU with NHS body, but would need to be with all partners in the place. **If selected with option 4**, the place is more empowered to act through a formal delegation through the individual director and has a clearer line of assurance to the ICS NHS body. **Suggested ability:** MEDIUM	**Suggested ability:** MEDIUM / HIGH *(depending on composition of Committee and ToRs)* Empowered to act through formal delegated accountability and decision-making to the place-based committee of the ICS NHS body. Assurances between partners in the place would be through membership of the place-based committee of the ICS NHS body. Assurances to the community would be through formal reporting to the ICS NHS Body, which could request that the place-based committee of the ICS NHS body meets in public. Assurances to the system would be via reporting to the ICS NHS Body. Risk that this is perceived as an NHS-only or NHS-driven group, as it is a committee of an NHS body.	**Suggested ability:** MEDIUM / HIGH *(depending on composition of Committee and ToRs)* Empowered to act through formal delegated accountability and decision-making to the to the place-based joint committee of the statutory partners. Assurances between partners in the place would be through delivery of agreed delegations from each statutory partner. Risk that this excludes non-statutory bodies. Assurances to the community would be through formal reporting to statutory organisations, which could request that the place-based joint committee of the statutory partners meets in public. Assurances to the system would be via reporting to the relevant statutory organisations, including the ICS NHS Body.	**Suggested ability:** LOW *(as a standalone option)* Only the individual director of the ICS NHS body is empowered to act. Therefore, no collective empowerment to the place if selected as a standalone option, except through engagement of the individual director with other partners. Assurances between partners in the place would rely on relationships between partners and a robust partnership agreement if selected as a standalone option. Assurances to the community would not be address if selected as a standalone option. Assurances to the system would be through the individual director of the ICS NHS body if selected as a standalone option. **If selected with option 1,** the place-based partnership has greater empowerment to act and assurances to the system would be via reporting to the ICS NHS Body. **Suggested ability:** LOW / MEDIUM *(depending on strength of partnership)* **If selected with options 2 or 3**, the place-based partnership has greater empowerment to act and assurances to the system would be via reporting to the ICS NHS Body and/or the relevant statutory organisations. **Suggested ability:** MEDIUM / HIGH	**Suggested ability:** LOW / MEDIUM *(depending on ways of working of lead provider)* Empowered to act through formal delegated accountability and decision-making to the lead provider. Therefore, no collective empowerment to the place if involvement of wider partners is not robust. Assurances between partners in the place would rely on relationships between partners and a robust partnership agreement. Assurances to the community would be through the governance arrangements of the lead provider statutory organisation. Assurances to the system would be via reporting to the ICS NHS Body.

6.4. These ratings are summarised below:

	Option 1	Option 2	Option 3	Option 4	Option 5
	Place-based partnership board (Consultative forum)	**Committee of ICS NHS Body**	**Joint committee**	**Delegated authority to individual director**	**Lead provider contract**
Collective ownership and accountability	**LOW/MEDIUM** **With option 4 MEDIUM**	**MEDIUM/HIGH** **With option 4 MEDIUM/HIGH**	**MEDIUM/HIGH** **With option 4 MEDIUM/HIGH**	**LOW** **With option 1 LOW/MEDIUM** **With options 2 or 3 MEDIUM/HIGH**	**LOW/MEDIUM**
Collective decision-making	**LOW/MEDIUM** **With option 4 MEDIUM**	**MEDIUM/HIGH** **With option 4 MEDIUM/HIGH**	**MEDIUM/HIGH** **With option 4 MEDIUM/HIGH**	**LOW** **With option 1 LOW/MEDIUM** **With options 2 or 3 MEDIUM/HIGH**	**LOW/MEDIUM**
Empowered to act / clear assurance processes	**LOW/MEDIUM** **With option 4 MEDIUM**	**MEDIUM/HIGH**	**MEDIUM/HIGH**	**LOW** **With option 1 LOW/MEDIUM** **With options 2 or 3 MEDIUM/HIGH**	**LOW/MEDIUM**

7. Key questions for consideration by the place-based partnerships

7.1. Using section 6 as a guide, and reflecting on your experiences of working across the system and in places, each place-based partnership is asked to consider the following questions:

7.1.1. From April 2022, and for the duration of the financial year 2022/23, should each of the five place-based partnerships in LSC adopt the same model for their governance arrangements, selected from the options set out in the Integrated Care Systems: design framework?

7.1.2. For each of the five options, do the points identified against each of the three key principles capture the key issues, risks, challenges, and concerns that need to be considered?
If not, what is missing or what needs to be amended?

7.1.3. For each of the five options, does the suggested summary of HIGH, MEDIUM or LOW reflect your thoughts on the overall ability of the option to meet the three key principles?
If not, how would you amend these?

7.1.4. Which of the options, or combination of options, would best support effective planning and delivery of a place-based strategy?
Why?

7.1.5. Which of the options, or combination of options, would best support engagement of all partners in the place-based partnership?
Why?

7.1.6. Which of the options, or combination of options, would work best for your place-based partnership?
Why?

7.1.7. Which of the options, or combination of options, would you not wish to use in your place-based partnership?
Why?

8. Feedback and next steps

8.1. Feedback from discussions in the five place-based partnerships will be collated and reviewed by the ICP Directors, with a **high-level summary** of views circulated to ICP DAG members and provided to the ICS development Oversight Group on 14th September 2021. This feedback will be anonymised.

8.2. A more detailed review of the feedback from the five place-based partnerships on each of the options will take place in the ICP Development Advisory Group on 15th September 2021. This feedback will also be anonymised.

8.3. An extraordinary ICP DAG has been scheduled for 28th September 2021, should any further discussions be required.

8.4. The outputs from the discussions in the ICP DAG meetings will be used to shape proposals that are ready for review by the ICS development Oversight Group on 12th October 2021 and subsequent decision-making via the ICS Board.

9. Recommendations for the place-based partnerships

9.1. Each place-based partnership is asked to:

1.1.1. **Note** the content of the relevant national guidance

1.1.2. **Respond to** the key questions set out in section 7 regarding the ability of the five options to meet the three key principles of our partnership working at place.

1.1.3. **Note** the timetable for review of feedback to shape future proposals.

Appendix A
Integrated Care Systems: design framework, published by NHS England, June 2021
Extract from section on Governance and management arrangements:

Place-based partnerships

"Partnerships between organisations to collectively plan, deliver and monitor services within a locally defined 'place' have a long history. These place-based partnerships have typically been established by local agreement according to their context and this bottom-up approach has been an important enabler to meaningful collaboration. However, as part of the development of ICSs, we now expect that place-based partnerships are consistently recognised as key to the coordination and improvement of service planning and delivery, and as a forum to allow partners to collectively address wider determinants of health.

We have asked each system to define its place-based partnership arrangements, covering all parts of its geography, agreed collaboratively between the NHS, local government and other system partners working together in a particular locality or community.

There is no single way of defining place or determining a fixed set of responsibilities that a place-based partnership should hold. All systems should establish and support place-based partnerships with configuration and catchment areas reflecting meaningful communities and geographies that local people recognise. In the smallest ICSs, the whole system may operate as a single place-based partnership. The arrangements for joint working at place should enable joined-up decision-making and delivery across the range of services meeting immediate care and support needs in those local places but should be designed flexibly to reflect what works in that area.

The ICS NHS body will want to agree with local partners the membership and form of governance that place-based partnerships adopt, building on or complementing existing local configurations and arrangements such as Health and Wellbeing Boards. At a minimum, these partnerships should involve primary care provider leadership, local authorities, including directors of public health, providers of acute, community and mental health services and representatives of people who access care and support

The ICS NHS body will remain accountable for NHS resources deployed at place-level. Governance and leadership arrangements for place-based partnerships should support safe and effective delivery of the body's functions and responsibilities alongside wider functions of the partnership. Each ICS NHS body should clearly set out the role of place-based leaders within the governance arrangements for the body.

An NHS ICS body could establish any of the following place-based governance arrangements with local authorities and other partners, to jointly drive and oversee local integration:

- *consultative forum, **informing** decisions by the ICS NHS body, local authorities and other partners*
- *committee of the ICS NHS body with delegated authority to take decisions about the use of ICS NHS body resources**
- *joint committee of the ICS NHS body and one or more statutory provider(s), where the relevant statutory bodies delegate decision making on specific functions/services/populations to the joint committee in accordance with their schemes of delegation*

***** *Contracts would be awarded and held, and payments made, by the ICS NHS body as the legal entity.*

- *individual directors of the ICS NHS body having delegated authority, which they may choose to exercise through a committee. This individual director could be a joint appointment with the local authority or with an NHS statutory provider and could also have delegated authority from those bodies*
- *lead provider managing resources and delivery at place-level under a contract with the ICS NHS body, having lead responsibility for delivering the agreed outcomes for the place.*

Effective leadership at place level is critical to effective system working, but the specific approach is to be determined locally. The roles of place-based leaders will include convening the place-based partnership, representing the partnership in the wider structures and governance of the ICS and (potentially) taking on executive responsibility for functions delegated by the ICS NHS body CEO or relevant local authority."

Appendix B

	Option 1 Consultative Forum	Option 2 Committee of ICS NHS Body	Option 3 Joint committee	Option 4 Delegated authority to individual director	Option 5 Lead provider contract
Description	Partnership informs decisions by the ICS Body, local authorities and other partners	A committee of the ICS NHS body with delegated authority to take decisions about the use of ICS NHS body resources	The ICS NHS body with one or more statutory bodies would delegate decision making on specific functions/services/ populations to the specified joint committee in accordance with their schemes of delegation	An individual director would have delegated authority from the L&SC NHS Body around the L&SC NHS budget that is allocated to place. Delegations would be set out in the organisation's scheme of delegation.	Lead provider holds the contract with the ICS NHS Body and has lead responsibility for delivering the agreed outcomes for the place
Key features	Not a legal form Contracts would be awarded and held, and payments made, by the ICS NHS body as the legal entity. Likely to require a partnership agreement to set out terms of collaboration/ principle of joint working Needs clarity on actions to be taken when partnership decisions are made. *Could be 3 different models: 1. purely a forum that brings together partners to discuss issues/proposals. Does not make decisions. Decisions are taken back through each individual organisation. 2. Representative from ICS NHS Body has delegated authority. 3. Every partner on forum has delegated decision making from their organisation	Committee informs/guides place based decisions on NHS spend Contracts would be awarded and held, and payments made, by the ICS NHS body as the legal entity. Cannot be formally formed until the NHS ICS Body is established.	ICP partners including NHS organisations and local authorities, etc, choose to come together and formally delegate budgets/decision making to a joint committee. Cannot be formally formed until the NHS ICS Body is established.	The lead director will co-ordinate the ICS NHS Body's allocation of resources in place (budget and people) This individual director would work with partners in place to facilitate joint working and joint decision making They would work closely with all partners to ensure accountability for delivery and expenditure within the place. The lead director could also discharge their accountabilities through a committee/the Place Based Partnership Board	New services contract would need to be awarded to Lead provider in the place One main contract/budget Sub-contracting and supply chain management done by Lead provider Risk transfer to Lead Provider
Benefits	Engages a wide range of members to discuss and agree shared strategic direction for the Place. Allows collective decision making based on individual delegations of authority Allows a partnership strategy to be agreed. Many places already have these arrangements in place. Can reflect equality of partners if each individual on the forum has the mandate to make decision on behalf of their organisation/network. Model is achievable for L&SC by 1st April 2022, and potentially in shadow for ahead of this date.	Would allow some partner engagement on committee and influence NHS spend. Other areas of the country are looking to establish this model now during transition through CCG governance and having a committee of the CCG. Once NHS ICS Body is legally established can transfer over responsibility. Could be useful for pooled funding arrangements Can agree to delegate to providers to achieve population health outcomes.	Enhances opportunity for pooling/aligning budgets with place level partners. Potential for high levels of delegation with more than one partner within the place Will make it easier to put additional joint arrangements in place, including s75 Agreements. Ability to make local, cross-organisational decisions with regards to specific functions/services/ populations within place Can agree to delegate to providers to achieve population health outcomes Collaborative decision making can be through an alliance agreement.	Retains a single SRO for decisions and gives clarity on how the NHS body at L&SC level interacts within place. Demonstrates commitment from the ICS to place based working and improving outcomes. Strengthens the accountability for place in delivering improved benefits and outcomes. A supporting committee would ensure local providers and other partners are able to influence decisions. Model is achievable for L&SC by 1st April 2022	Clarity on accountability for delivery. Gives providers greater ownership and direction for the delivery of services
Risks	Decision making is through individuals on the group, not as an entity in its own right and decisions may need to be ratified through organisational bodies.	Doesn't initially involve any wider delegated budgets and is NHS focused.	The Place Partnership would need to demonstrate its ability to manage finance/take decisions especially around allocation/ accountability for the place.	Role changes will be required, including redistributing of power relationships	Could prevent more innovative forms of provider collaboratives emerging and feels as though it will have limited value

NB: Some of supporting information is drawn from Hill Dickinson LLP – "*White Paper briefing - ICS, Place and Provider Collaboratives", March 2021*

	Not able to hold budgets directly. Risk if this isn't constituted properly, it would only be a consultative forum. Limits the opportunity for mutual accountability between partners.	Full partner engagement in decision making will be limited. Role changes will be required, including redistributing of power relationships Doesn't address the L&SC ambition to have a whole system/whole partnership agreement on place-based budgets which is inclusive of all partners Cannot commence until ICS NHS body is formed. Therefore, unlikely that this model is achievable for 1st April 2022, given the scale of changes already underway in the system.	This will require formal agreements to be developed. Experience from some areas suggests there could be issues with accountability and clarity of decision taking. Will require the partnership to pay greater attention to the need for equitable voices in decision making. Post April 2022, section 75 arrangements will be with the new ICS NHS Body. Whilst further information is awaited re section 75 legislation, it could be difficult to reset section 75 arrangements. Complex and time-consuming model to agree. Therefore, unlikely that this model is achievable for 1st April 2022 given the scale of changes already underway in the system.	Currently no examples of where this is happening. Will require significant partnership working across the place to ensure decision making is collaborative. Financial position of the health and care system is very challenged, which places heavy responsibility on an individual to support financial sustainability	to voluntary sector/local government partners. Putting decision making into a single organisation as opposed to a partnership. Assurances could be needed around co-production of service outcomes. Likely to need a mechanism of ensuring wider partner influence to drive focus on improving population health Will require the partnership to pay greater attention to the need for equitable voices in decision making – this would require a significant OD effort for any provider wishing to take this on. Provider would need to have the set up and infrastructure to take on the responsibility with agreed authority from other partners. Currently no examples of this model and not previously explored in L&SC for places

NB: Some of supporting information is drawn from Hill Dickinson LLP – "*White Paper briefing - ICS, Place and Provider Collaboratives", March 2021*