Proposed Governance Arrangements for a Combined Berkshire West ICS and Berkshire West 10 - Main Report – Final Draft

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Introduction

1.1. It was agreed at the Chief Officers Workshop held at the Hilton Hotel in Reading on 19th November 2018 that one of the three priorities moving forward should be a review of the governance structures for the Berkshire West Integrated Care System (BWICS) and the Berkshire West Integration Programme (BW10). The aim was to produce a single governance structure for both. At the same time the workshop also agreed that project resourcing for any new combined governance structure should also be considered. It was agreed that existing BCF funding should be looked at as a potential source for this along with current NHS Transformation funding.

1.2. The need to potentially integrate the BW10 and ICS governance structures began to emerge early in 2018. It was becoming clear that the two governance structures were seen as increasingly difficult to support. Churn in senior staff, most notably within local government, was also exacerbating capacity constraints in senior leadership teams. The need for change was seen if only because the existing arrangements were viewed as unsustainable. A start towards the bringing together of the two governance regimes was made in August 2018 with the combination of the BW10 Integration Board and the Chief Officers Group.

1.3. The purpose of this Paper is to set out a set of proposals for bringing the two current governance arrangements together. In doing so a review is undertaken of the current arrangements but also of the newly emerging NHS architecture which is beginning to form following the publication of the NHS Long Term Plan (NHS LTP). Having considered the governance arrangements, the Paper moves on to consider how the new integrated Programme might best be supported across Berkshire West.

2. Background - Overview

2.1 The Berkshire West Integration Programme (BW10) was established in 2014 and brought together both local Health partners and local government. It was a natural development of the Chief Officers Group which was established in 2013 following the implementation of the Health and Social Care Act (2012). Its initial focus was heavily geared towards improved integration of Elderly Frail services alongside management of the Better Care Fund (BCF). Latterly it developed a more expansive vision which proved more challenging to implement.

2.2 When the BWICS was originally conceived in 2016 there was an agreement that the initial focus would be on the three main health partners, the then four clinical Commissioning Groups which are now one (CCG), the Berkshire Healthcare Foundation Trust (BHFT) and the Royal Berkshire Hospital (RBH) moving forward a programme of Health integration. The expectation was that the three Unitary Authorities would join the BWICS some two years later. Whilst this did not become a formal discussion during 2018 it was evident that the agendas of the BW10 and BWICS two groups were beginning to merge. Indeed at the Chief Officers Group workshop in November 2018 a venn diagram was produced which highlighted the agendas of the two Groups and the areas of common interest (see Appendix 1).

2.3 The issue was further highlighted in the Reading Local System Review which was conducted in October/November 2018 by the CQC. Whilst focused on Reading, the

Review also considered the work of the BW10 and BWICS and made the following observations;

(1) the strategic direction of the Berkshire West 10 was set out by Chief Officers representing the member organisations. There were strong relationships between the Chief Officers, but the strategic vision for the Berkshire West area, including Reading, had not yet been articulated into a credible strategy that was agreed by, and understood by, all partners. As a result it was not clear to people who use services (or staff) how the strategy for the delivery of health and care services in Reading was aligned to the vision for the Berkshire West area;

(2) health partners had led the development of the Berkshire West Integrated Care System (ICS) in 2016 and were in support of merging the work of the BW10 into the ICS. Historically there had been reluctance from some local authority partners for this direction of travel, but opportunities for alignment were being explored and supported through recent meetings between the Chairs of the Health and Wellbeing Boards in the three unitary authorities;

(3) in terms of the key areas for improvement the CQC cited the following which are relevant to this Paper;

(a) in developing the next Health and Wellbeing Strategy, due for publication in 2020, the local authority should engage system partners and ensure greater alignment with the wider Berkshire West ICS's strategic intentions and those of the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability and Transformation Partnership (STP);

(b) health and care commissioners should work together to develop the new Joint Strategic Needs Assessment (JSNA) and ensure that its development is aligned with the ICS's Population Health Management approach;

(c) health and care commissioners should develop a joint commissioning strategy. Health and care commissioners should agree on commissioning intentions across health and social care and work together to develop a joint market position statement (this is being taken forward as a separate work stream by the Chief Officers Group (COG));

(d) system leaders should focus on developing prevention and early intervention services that increase the support offer in the community. A system approach to risk stratification and active case management should be developed to identify people at the highest risk of hospital admission;

(e) while relationships between system leaders were strong, relationships between health and local authority partners could be improved. As the system moves towards greater integration at a Berkshire West level, system leaders should ensure that staff are engaged in the process

and that health partners are working with colleagues in the local authority to progress plans;

(f) system leaders should evaluate governance boards and processes to ensure that there is no duplication. System leaders should also ensure that people working in the system are clear on where decisions are taken, and where accountability lies for system performance (the latter point is a particular focus for this Paper).

2.4 A key point to take from these comments is that the future direction of the BW10/BWICS work needed to be clarified before any meaningful decisions could be taken on future governance and resourcing. This is reflected on later in the Paper.

2.5 It is also important to realise that Berkshire West does not exist in isolation. There are three local authorities within Berkshire West and each has its own Health and Wellbeing Board and BW10 Locality Board. In the past, links between the BW10/BWICS and Health and Wellbeing Boards have been tenuous. This has led to something of a deficit in Elected Member engagement which also needs to be addressed as part of this Paper. Primary Care Networks (PCNs) are also now being discussed and these are being taken forward at a geography smaller than each of the three unitary authorities.

2.6 The BOB STP has already been mentioned and is an important dimension to consider when determining what should be planned and delivered at a Berkshire West level. There is an ongoing debate at the STP regarding what activities are best co-ordinated at scale across BOB and what are best managed more locally. As this Paper is being written this debate continues and has now been crystallised to a degree through the publication of the NHS Long Term Plan (NHS LTP). This newly emerging context is now an important element to consider in the development of any new integrated governance arrangements locally.

3. Current Context

3.1 Before considering how to move forward across Berkshire West it is perhaps worth providing some further context to the wider health and social care system and the potential impact of ongoing announcements at a national level. What are seen as the most significant developments are set out below.

The NHS Long Term Plan (NHS LTP)

3.2 The new NHS Long Term Plan (NHS LTP) was published in January 2019. It followed on from the Five Year Forward View (5YFV) which was published by the NHS in October 2014 and which set out a blueprint for the future provision of care in England and introduced the concept of Integrated Care models which have subsequently developed into Integrated Care Systems (ICSs).

3.3 The new NHS LTP sets out a proposed direction for the NHS over the next 10 years. A set of priorities are laid out within the Plan which will undoubtedly be the subject of future discussion. The key points that are perhaps relevant to this Paper are;

(a) there is an expectation that there will be ICSs in place across the country by 2021;

(b) it appears that future ICSs are expected to have a minimum population footprint of 1 million or more. This rules out Berkshire West and the assumption going forward is that BOB will be the geography for the new ICS;

(c) additionally, it is suggested that commissioning arrangements will typically involve a single CCG for each ICS area. It remains unclear how this will be organised.

3.4 Late last year the NHS released a proposed infrastructure which would be used to help shape future health and social care governance arrangements. This was essentially based on three layers within a local architecture – namely, System, Place and Neighbourhood. Locally, the term Locality has also been introduced into this new taxonomy. It is important to bear in mind that this new taxonomy or architecture is for planning not necessarily delivery purposes and the NHS appear to accept that organisations may continue to be based on a geography that that does not align with what is set out below. The suggested local interpretation of this new planning taxonomy is shown in Fig. 1 and summarised below:

(a) *System* – the ICS is seen to embrace the 'System'. At the moment it appears to be assumed that this will be BOB. Currently the ICS is based on Berkshire West. There is also an ICS for Buckinghamshire. Both sit within BOB:

(b) *Place* – it is assumed that this would be Berkshire West. Roles and responsibilities between System and Place are only now being formally discussed:

(c) *Locality* – it is assumed that in a local context the three localities will be Reading, West Berkshire and Wokingham. These reflect the boundaries of the three unitary authorities. Each Locality also has its own Health and Wellbeing Board and its own BW10 Locality Board. Partners are engaged in both. This is also the geography at which the Health Scrutiny currently takes place.

(d) *Neighbourhoods* – these are assumed to be the new Primary Care Networks which are at an early stage of being established. Neighbourhoods are optimally seen to support a population of between 30,000 – 50,000 and so are smaller than the Berkshire West defined Localities. These Neighbourhoods have yet to be defined.

3.5 As stated earlier delivery is likely to be achieved through individual organisations or through various 'partnership' arrangements. There is no expectation that these will align to the above taxonomy and there are a number of examples of this;

(1) RBH serves a population that is not coterminous with Berkshire West. There is a relatively good fit but some residents of West Berkshire are served by the North Hants Hospital in Basingstoke and the Great Western Hospital in Swindon. The RBH also serves Bracknell.

(2) BHFT provides services across Berkshire.

(3) Public Health, whilst being organised in part at a Locality level, is established as a shared service for the whole of Berkshire.

3.6 If the architecture in Fig.1 is being prescribed then the future governance will need to reflect it. We are not however starting from a blank sheet of paper so in terms of a new approach it is important to be mindful of what is already in place. A brief review is set out below.

The System - BOB

3.7 STPs emerged as Sustainability and Transformation Plans (plans were replaced by Partnerships in 2017) in the NHS Planning Guidance published in December 2015. This followed publication of the 5YFV. Berkshire West was placed within the Buckinghamshire, Oxfordshire and Berkshire West STP known locally as the BOB STP. There was a general feeling that this geography was unnatural and that it brought together three local areas that previously had little history in working together, in particular Berkshire West.

3.8 The original concept behind STPs was that NHS organisations and local authorities in different parts of England would come together to develop 'place-based plans' for the future of health and care services in the area. Draft plans were produced by June 2016 and final plans were submitted in October of that year. The original expectation was that the plans would cover;

(a) improving quality and developing new models of care;

(b) improving health and wellbeing;

(c) improving efficiency of services.

3.9 They were expected to cover the period October 2016 – March 2021.

3.10 The BOB STP Plan was published in 2016 and set out the following priorities;

(1) shifting the focus of care from treatment to prevention;

(2) providing access to the highest quality primary, community and urgent care;

(3) collaboration between acute trusts to deliver equality and efficiency;

(4) developing mental health services to improve the overall value of care provided;

(5) maximising value and patient outcomes from specialised commissioning;

(6) establishing a flexible and collaborative approach to workforce;

(7) making better use of digital technology to improve information flow, efficiency and patient care.

3.11 In July 2018 the BOB STP in terms of overall progress was judged as Category 2 'Advanced' whilst System Leadership was described as Category 3 'Developing' (1 = High scoring 4 = Low).

3.12 The STP governance arrangements as at November 2018 are set out in Appendix 2. There are a number of work-streams some driven by the STP Plan and others by the national 5YFV. The work-streams are;

(1) Population Health Management (STP)

(2) Prevention (STP)

(3) Capacity planning (STP)

(4) Digital (STP)

(5) Estates (STP)

(6) Workforce (STP)

(7) Cancer (FYFV)

(8) Urgent and Emergency Care (FYFV)

(9) Maternity – Better Births (FYFV)

(10) Mental Health

3.13 The BOB STP is supported by a Team of 7 staff including an Executive Chair. Governance is primarily through the Chief Executive's Group which in the context of Berkshire West includes the Accountable Officer from the CCG, the Chief Executives of BHFT and RBH and the Chief Executive of West Berkshire Council who represents all three West Berkshire Unitary authorities.

3.14 As stated earlier the NHS LTP clearly sees an ongoing role for the STP. The BOB STP is currently seen as the future System and also as the future ICS. At this point the STP is aligning its activity very closely to the new NHS LTP. In some respects this is helpful but the LTP is very NHS focused and there is a risk that the BOB STP agenda becomes dominated by Health matters and increasingly irrelevant to the other partners.

3.15 Work has already began at the BOB STP / ICS to determine its future strategy and governance arrangements. These are still at a formative stage and are expected to be concluded towards the end of 2019. For the purpose of this report the BOB STP and the BOB ICS are essentially the same thing. The former is expected to morph into the latter over the coming months.

3.16 The proposal at the moment is to align the future BOB STP/ICS strategy to that set out in the NHS LTP. The latter is seen to have seven distinct themes;

(1) Integrated care:

(2) Prevention and inequalities:

(3) Care quality and outcomes:

(4) Workforce:

(5) Digital:

(6) Efficiency:

(7) Engagement & partnerships.

3.17 As can be seen there is a strong alignment with the existing work streams that were highlighted earlier. Additional work has also suggested that these work streams also align well with the Place based strategies that have been developed within BOB. However there are a small number of areas where it is felt the Place based strategies have a particular emphasis which is yet to be replicated at a BOB STP level. These include;

(1) Reducing inequalities;

(2) Clinical priorities e.g. long term conditions, learning disabilities, maternity etc;

(3) Patient experience/voice;

(4) Prevention.

3.18 Table 1a sets out some early thoughts as at February 2019 from the BOB STP on how these NHS LTP themes are best taken forward and in particular how roles and responsibilities might be allocated between System and Place. This clarifies the role that the STP currently sees Place as having with each of the seven themes shown in paragraph 3.16. It is noteworthy that in many instances the role of the STP is to bring together what has been created at Place or to act in a quality assurance capacity. In summary;

(1) *Integrated Care* - Designed and delivered at Place. The System role would be to share good practice and encourage collaboration.

(2) *Prevention and Inequalities* - Designed and delivered at Place. As above the System role would be too share good practice and encourage collaboration.

(3) *Care Quality and Outcomes* - Designed and delivered at System level but delivered at Place or Organisational level

(4) *Workforce* - Designed and delivered largely at System with delivery left to Place or Organisation.

(5) *Digital* - Designed and delivered at Place level. The System role would be to encourage collaborations. Delivered at Place or Organisation level.

(6) *Efficiency* - Designed and delivered at Place Level and amalgamated / added to at System level.

(7) *Engagement and Partnerships* - Designed and delivered at Place level with System sharing good practice and encouraging collaboration.

3.19 If taken forward this would leave a significant role for Berkshire West both in terms of design and in delivery. This is helpful in clarifying what Berkshire West is likely to have to govern going forward. What Table 1a does not do is clarify what would be

done at Locality and Neighbourhood level. This has not been considered by the BOB STP but is reflected later on in this Paper.

The Place – Berkshire West

3.20 Berkshire West is seen as the boundary for the local health economy although it is by no means an impermeable boundary with significant patient flows both out of and into the area. The Clinical Commissioning Group (CCG) is based on the Berkshire West boundary as is the current BW ICS.

3.21 At first sight it would seem that the focus on Berkshire West may diminish somewhat with the future ICS being based on the BOB boundary and the future structure of CCGs also being potentially aligned to this boundary. However, as noted in Table 1a the BOB STP/ICS is already moving towards a highly delegated structure where many of the essential building blocks going forward will remain at the Place level. Mention has already been made of the BW10 and BWICS arrangements which underpin health and social care planning across Berkshire West. These are now being brought together but it is important to review their current work activities prior to any consideration as to future governance.

Berkshire West 10

3.22 The Berkshire West 10 Partnership was established in 2014. It brought together the then four CCGs, three unitary authorities, two NHS providers and the South Central Ambulance Service. The governance eventually settled around an Integration Board which provided strategic direction and oversight, a Delivery Group which focused on co-ordinating operational delivery and three Locality Boards aligned to the boundaries of the three unitary authorities (see Appendix 4a). Links to the Health and Wellbeing Boards have not been particularly strong. Neither has Elected Member engagement. Both need addressing going forward.

3.23 The initial work of the BW10 was focused on the Elderly Frail and the coordination of the Better Care Fund (BCF). The latter emerged in 2015.

3.24 A more developed Vision emerged in 2017 (see Appendix 3a) which embraced four distinct strands:

(1) Frail elderly:

(2) Mental health and Learning Disabilities:

(3) Prevention:

(4) Children:

3.25 Progress with implementing this wider Vision proved problematic and limited progress was made. In August 2018 the BW10 Integration Board was effectively abolished and merged with the extant Chief Officers Group.

3.26 The BW10 Delivery Group has continued to meet and remains well attended. It has a number of active work streams most notably:

(1) Care Homes Project for which there is a separate Project Board:

(2) Trusted assessor:

(3) Connected care for which there is now a new Project Board:

(4) CHS (Provider for self funder discharge from hospitals):

(5) SCAS falls project:

(6) CHASC working:

(7) Step up beds – Wokingham:

(8) WISH Team – Wokingham:

(9) Integrated Hub – Wokingham:

(10) Integrated Care Team – West Berkshire:

(11) Additional Capacity – West Berkshire:

(12) Step down beds – West Berkshire:

(13) Discharge to assess (Willows) – Reading:

(14) Community Reablement Team – Reading.

3.27 The above reflects what is currently being supported in part by BCF funding across Berkshire West. A number of the above projects are now becoming 'business as usual' and can now be removed from this list.

3.28 Table 2 sets out in more detail the staffing resources that are being used within the BCF budget to manage the current BW10 programme. The general view is that it is these resources which need to reshaped to support an integrated Berkshire West Programme moving forward. This is reflected on later.

Berkshire West ICS

3.29 The Berkshire West Integrated Care System (BWICS) was established in 2015, and was recognised by NHSE as an ICS Exemplar Area in June 2017. It is one of 10 ICSs across England. It was agreed from the outset that the ICS would focus on Health integration and therefore it has not included Local Government to date. The expectation was that local authorities would join after 2 years but in practice this has not happened.

3.30 The main objective of the BWICS is cited as ensuring that the population's experience of healthcare services:

- continues to improve;
- continues to benefit from improved health and wellbeing outcomes, and that;
- the local NHS is financially sustainable for the future.

Specifically this is seen to mean;

(1) making faster progress in transforming the way care is delivered, as set out in the 5YFV, and in particular making tangible progress in urgent and emergency care reform, strengthening general practice and improving mental health and cancer services;

(2) managing these and other improvements within a shared financial control total and to deliver the system wide efficiencies necessary to manage the local NHS budget;

(3) integrating services and funding, operating as an integrated health system and manage the health of the local population, keeping people healthier for longer and reducing avoidable demand for healthcare services;

(4) demonstrating what can be achieved with strong local leadership and increased freedom and flexibilities, and share learning with the wider NHS.

3.31 The current strategic priorities and key projects for the BWICS are set out in Appendix 3b. The priorities are set out as to:

(1) Develop a resilient urgent care system that meets the on the day need of patients and is consistent with constitutional requirements:

(2) Design care pathways to improve patient experience and clinical outcomes, and make the best use of clinical and digital resources:

(3) Progress a whole system approach to transforming primary care to deliver resilience, better patient outcomes and experience and efficiency:

(4) Develop the ICS infrastructure to deliver better value for money and reduce duplication:

(5) Deliver the ICS financial control total agreed to by the Boards of the constituent statutory organisations.

3.32 The governance arrangements for the BWICS comprise a Leadership Board, and Executive along with supporting Programme Boards, Reference Groups and Enabling Groups. This is set out in Appendix 4b.

The Localities

3.33 The three Localities (Reading, West Berkshire and Wokingham) each have a Health and Wellbeing Board. The Boards were created through the Health and Social Care Act 2012. Health and Wellbeing Boards are a formal committee of the local authority charged with promoting greater integration and partnership between bodies from the NHS, public health and local government. They have a statutory duty, with CCGs, to produce a joint strategic needs assessment and a joint health and wellbeing strategy for their local population. The Boards have very limited formal powers being constituted as a partnership forum rather than an executive decision making body. The Board must include a representative of each relevant CCG and local Healthwatch as well as local authority representatives. The local

authority has considerable discretion in appointing Board members and some have over time sought to broaden the remit of the Board to something akin to that of previous Local Strategic Partnerships which were created in the early 2000's under the Local Government Act 2000.

3.34 The degree to which HWBBs have linked effectively to BW10 and BWICS is a moot point. Elected Members have not been represented within either Programme and the BWICS has no formal Locality focus. The Better Care Fund (BCF) which has been a major driver behind the BW10 does link that Programme to HWBB's through the Locality Boards but how effective that link is remains unclear.

3.35 The BW10 Locality Boards are, as the name suggests based around Localities. They are strongly linked to the BW10 Delivery Group less so to the HWBBs. Their focus has been almost entirely on managing the Better Care Fund (BCF). Most of this BCF funding has now been absorbed into operational budgets with activity now increasingly becoming business as usual. There is a question over the role of the Locality Boards moving forward.

3.36 Localities are also the geographical level at which Health Scrutiny takes place. This is a responsibility of the local authority through Overview and Scrutiny Committees.

3.37 Table 1b provides some thinking on what the responsibilities of Locality might be contrasted with those of Place. Once again the NHS LTP themes have been used to help frame this but areas where it is felt Localities should lead include;

(1) development and support for Primary Care Networks (Neighbourhoods);

(2) some prevention work and a strong focus on health inequalities;

(3) engagement and partnerships including the patient experience and voice;

(4) the development of health and wellbeing strategy (to be amalgamated at Place);

The Neighbourhoods

3.38 Primary Care Networks (PCNs) are seen as building blocks for Neighbourhoods. It is currently estimated that there will be 13 PCNs or Neighbourhoods across Berkshire West (Place). It is unclear at this point whether PCNs will be coterminous with the three Localities. Whilst still at an early stage in development PCNs are a key feature of the NHS LTP and are seen as clusters of existing GP surgeries which will work towards (note in some cases some of this work is already underway);

(1) the establishment of integrated care teams;

(2) delivery of evening and weekend appointments;

(3) shared staff e.g. clinical pharmacists;

(4) shared back office;

(5) same day access models;

(6) the development of hubs.

Neighbourhoods are at an early stage of development but it is felt that the Localities should have a key role in shaping their development.

3.39 Before considering future governance proposals it is perhaps worth reflecting on the current strengths and weaknesses of our existing governance arrangements across Berkshire West.

(1) Strengths

(a) Strong lasting relationships most notably amongst Health partners where there has been less churn in senior leadership.

(b) Commitment to partnership working which in some areas has borne improved outcomes.

(c) An effective BWICS governance structure which appears to have supported progress at some pace.

(d) An active and engaged BW10 Delivery Group that has some notable achievements under its belt.

(e) Some effective sub groups within both the BW10 and BWICS structure which have also delivered significant achievements.

(2) Weaknesses

(a) Current lack of agreed Vision and strategic plan.

(b) Capacity - most notably at senior leadership level.

(c) Lack of engagement with Elected Members and with Health and Wellbeing Boards.

(d) Complex local arrangements with potential duplication.

(e) Strategic direction is fluid and subject to change – most notably within the NHS. This could undermine the effectiveness and sustainability of any agreed governance arrangements.

4. Governance Principles

4.1 The Kings Fund identifies ten design principles for place based systems of care. These are worth reflecting on prior to the design of a new governance for a combined BWICS/BW10. The 10 design principles are;

(1) define the population group and the system's boundaries. The proposed taxonomy in Fig 1 frames this very well and the articulation of what might be done at what level within that taxonomy is a very helpful step forward. This is an issue which has hampered integration work locally in the past;

(2) identify the right partners and services. The Kings Fund states 'while place-based systems of care will have a strong focus on the NHS they

should also involve local authorities, the third sector and other partners'. This is particularly the case where the aim is to focus on population health and not just health and care services. The inclusion of both providers and commissioners is also seen as important. The Locality is probably the level at which this wider level of engagement is likely to be best secured and is where broader discussions about health and wellbeing are best promulgated;

(3) develop a shared vision and objectives. The commentary here states 'the initial focus is likely to be on achieving the financial and clinical sustainability of local services as well as the development of new care models that cut across organisational and service boundaries'. Areas that have more experience in partnership working may chose to focus on the broader aim of improving population health and wellbeing from the outset. The BWICS/BW10 approach is still largely in the former camp although more recent developments highlight a broader approach is developing although more is needed to embed this. It would appear necessary to create a new more holistic vision and set of strategic objectives going forward;

(4) develop an appropriate governance structure – this is the purpose of this paper but the opening comment from the Kings Fund states 'governance arrangements must reflect existing accountabilities while also creating a basis for collection action. To do this successfully they must be inclusive enough to ensure that those involved in delivering and receiving services are meaningfully involved in decision making. They must also be strong enough to be able to coordinate the range of activities involved in meeting the group's objectives – something that is far easier said than done!'

(5) identify the right leaders and develop a new form of leadership – the Kings Fund states that 'ensuring that the right leaders are involved in managing the system of care at the appropriate level of seniority, including Chairs and Board members where appropriate, is essential. Much will depend on the strength of relationships between organisational leaders and the extent to which there is mutual trust and respect. The need for collaborative leadership is stressed as is the need for clinical leadership and the engagement of front line clinical teams if change is to be realised. Relationships at some levels are well developed but there has also been significant churn. Engagement of Elected Members and Health and Wellbeing Boards at Place is a significant current deficit;

(6) agree how conflicts will be resolved – the commentary states 'wherever possible, conflict should be viewed as a healthy reflection of the state of collaborative working and the ability of the organisations involved to disagree and move on. At the same time, partners should be clear about the consequences for organisations that fail to play by the agreed rules and behaviours of the system.' This is probably an area where some further work is required;

(7) develop a sustainable financing model – this has been advanced under the BWICS with some notable success. The work is far from complete but it has been a key objective of the BWICS agenda to date;

(8) create a dedicated team – teams are in place to support both BWICS and BW10. Resources also exist at the BOB STP and Locality Level. Part of the purpose of this paper is to reshape these teams to support the new integrated governance;

(9) develop systems within systems – there is an expectation that different programmes will develop within the Place based governance. It is stated that 'the important task is to ensure that activities of different groups from a coherent, mutually reinforcing approach, rather than becoming a disjointed set of initiatives;

(10) develop a single set of measures. The BWICS and BW10 both have their own sets of measures. These now need to be reviewed not only because BW10 and BWICS are being combined but also because they need to be fit for purpose. It is suggested that;

- there should be a small set of metrics to assess the overall performance of the Place, including how they will be circulated and reported to the public;
- a larger set of metrics should also be collected to allow partners to understand how they are contributing to the overall goal of the system and identify areas of improvement;
- this area requires further work locally.

(11) it is also suggested that measures should be used to test whether the Place is behaving in a way that aligns with its agreed values and behaviours e.g. how well teams are collaborating to deliver more coordinated services or how well shared decision making is embedded in the way that care is delivered. It is also stated that one of the risks in developing systems of care is that of adding further complexity to an already complex system. While this cannot be avoided entirely, the design of governance arrangements needs to be done in a way that minimises transaction costs and seeks to keep these arrangements as simple as possible.

4.2 There is as yet no clear vision and strategic plan for Berkshire West as a Place. The original Vision of the BW10 proved unachievable although there are undoubtedly elements of it that would remain relevant in any Programme aimed at improving patient outcomes and reducing cost across health and social care. There may be a need to retain some oversight of the BCF programme and in particular the work on reducing DTOCs which has proved successful in recent months. Some projects remain ongoing and need to be retained in any new governance arrangements others can, or have become business as usual. The BWICS has an active work programme and despite the NHS LTP much of what is currently in place would appear relevant in terms of any future arrangements.

4.3 The emerging BOB STP/ICS governance discussion does however highlight some current gaps in their proposed arrangements and these will need further consideration.

4.4 The Chief Officers Group identified three priorities late last year. One is being progressed through this Paper but the other two need to be picked up by the new arrangements most notably;

(1) Joint commissioning

(2) Effective neighbourhood working

4.5 Berkshire West also has a range of existing governance arrangements based around operational management. These include;

(1) A&E Delivery Board

(2) Planned Care Operational Group

(3) Finance Group

4.6 Many of these are effective and need to the retained within the new arrangements as well.

4.7 Consideration also needs to be given to how Locality and Neighbourhood working will relate to Place based planning and delivery based on Berkshire West. The BOB STP/ICS appears to be adopting a principle of subsidiarity in its relationship with the three Place based areas within it. Such a principle may not be appropriate in the Place's relationship with the three localities of Reading, West Berkshire and Wokingham but an understanding of what is best done at Place and at the Locality would seem essential if the new governance arrangements are to work effectively. Confusion and dispute on this particular issue has not served the BW10 well since 2014.

4.8 Given this context some guiding principles have been set for the newly proposed governance arrangements:

(1) They should be built on the 'four level taxonomy' as already outlined in Fig.1 providing clarity as to what each level is responsible for and how coordination will be effected between the different levels. Planning and delivery need to be differentiated as two different things.

(2) The new arrangements should be no more burdensome than the existing ones - ideally less so:

(3) The arrangements need to directly support the strategic direction adopted across Berkshire West and provide an effective means of working within the new BOB ICS:

(4) What is in place should be inclusive most notably with regard to Elected Members.

Towards a Vision and Strategic Plan

4.9 The absence of a vision and strategic plan creates something of a vacuum in terms of trying to shape governance around what needs to be achieved. Ultimately the work programme will be a combination of;

(1) what needs to be done to support the BOB ICS. (The BOB ICS has already produced an overview plan which highlights that it will delegate a significant amount of planning responsibility to Place – see Table 1a);

(2) aspirations at a Berkshire West level (some of which has been articulated through the Chief Officers Group). This requires further work;

(3) a consideration of the aspirations of each Locality as expressed through their Health and Wellbeing Strategies, and;

(4) the emerging aspirations of Neighbourhoods.

4.10 It is not the purpose of this governance paper to set out a clear Place based vision for the future although the latter is something of a prerequisite for the former. The following are however being assumed at this stage;

(1) an interim strategy will emerge later in 2019 which will be aligned to the strategy work being undertaken by the BOB ICS;

(2) a new Health and Wellbeing Strategy will be prepared collectively by each of the Localities which will then be aggregated at Place level. This will seek to bring together not only the collective ambitions for the area in respect of prevention, population health and health inequalities but will also seek to embrace the Place's overall ambitions with regard to integration and its response to the NHS LTP.

4.11 Whilst there is currently something of a strategic void to help guide this governance Paper it is necessary to create some form of strategic framework on which a new governance structure can be constructed. The following have been used to try and help achieve this;

(1) the themes set out in the NHS LTP;

(2) the plans of the three current Health and Wellbeing Boards;

(3) the existing programmes of activity that are being sponsored and delivered by the BW10, BWICS and the Chief Officers Group.

4.12 The three objectives of the current BWICS align very closely to those which were originally adopted by the BW10. It is proposed that these are retained for the ongoing Place based work. They are;

(1) an improvement in the health and wellbeing of our population;

(2) an enhancement of patient experience and outcomes;

(3) financial sustainability for all constituent organisations.

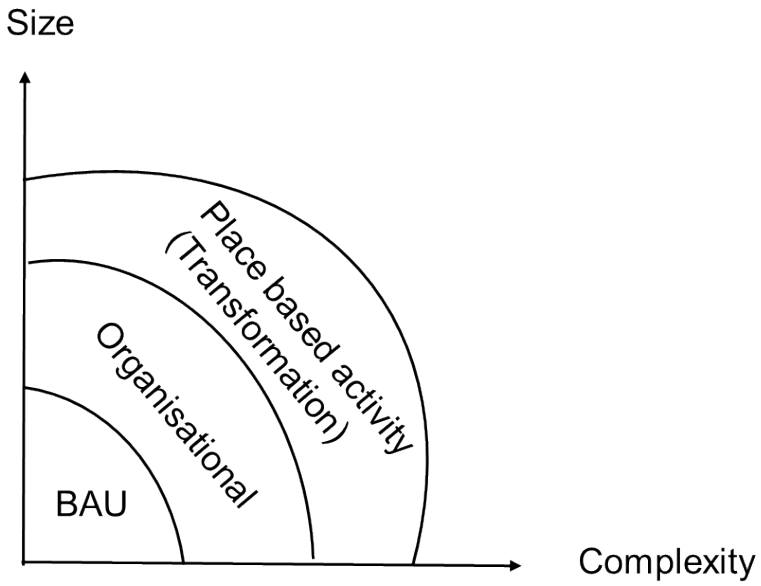
4.13 Appendix 3b highlights five strategic priorities for 2018/19 which were used to frame BWICS activity during that year. At this point it is not intended to include these but

rather list a number of proposed and existing projects which it is felt should be pursued during 2019/20. These are set out within the seven themes of the NHS LTP and highlighted in Table 3.

4.14 It must be stressed that this is very much an initial and provisional set of strategic objectives and projects aimed at seeking to provide an initial framework over which the governance can be shaped.

4.15 The earlier chapter highlighted the need to focus the governance around a clear understanding of what is seen as transformational activity as opposed to 'business as usual' activity. The approach adopted by BWICS is set out below and the same approach has been adopted here to aid the development of appropriate governance.

Fig 2 – Differentiating levels of activity



4.16 In framing the future governance the emphasis has been on the transformational element but it also has to be recognised that it is important that an oversight of the performance of Place is maintained and for this reason some oversight of business as usual and organisational change is also important

The Development of a Berkshire West Integrated Care Partnership

4.17 BW10 is no longer a correct term given that the 4 CCGs that made up BW10 in 2014 are now just one. At the same time the ICS looks set to move from Berkshire West to BOB so the term ICS also no longer seems appropriate. It is felt a new description is needed to embrace the new collective governance. Integrated Care Partnership or ICP is proposed since the term has been used elsewhere in the country to describe Place based structures. It also provides a clear link to the emerging BOB ICS which is seen a appropriate partly because Berkshire West was an ICS but also because it demonstrates Berkshire West's position within the wider ICS.

4.18 It is also proposed that the main building blocks of the current BW ICS and BW10 governance are retained although in all cases the membership will need to be broadened. Consequently the following are being recommended;

(1) ICP Leadership Board:

(2) ICP Executive:

(3) ICP Delivery Group.

4.19 The former two have their origins in the BWICS and the latter in BW10. The inclusion of the ICP Delivery Group is seen as essential to ensure that the ICP Executive is not swamped by reports from the supporting Programme Boards and other groups. Fig. 2 sets out the proposed structure including a range of supporting Programme Boards and enabling groups. These are currently provisional and subject

4.20 The Terms of Reference for each of the three main groups is set out in Appendices 5a-c but the key elements of each are set out below.

(1) BWICP Leadership Board – this would be drawn from all seven organisations making up the BWICP (see Fig.2). Alongside the existing membership Elected Members would be included along with the Chairs of the Health and Wellbeing Boards who would sit on the Group in an observational capacity. The Chief Executives of the unitary authorities would also become Members. The Board would continue to have an Independent Chair given the wide range of interests and scale of the agenda. The primary purpose of the Board would be to;

(a) act to optimise the ICP in delivering improved health and wellbeing outcomes and delivering better care for patients with increased cost effectiveness and;

(b) concentrate on the creation of strategy, building confidence with all Partners, approving of programmes, resolving strategic blockers, delegating to executives for implementation, and providing direct challenge where there is under delivery/performance;

(c) lead the development and articulation of the ICP strategy and oversee delivery of programmes and commitments;

(d) create a shared understanding of the vision and ensure that this is aligned with the objectives;

(e) intervene robustly to address shortfall in delivery and performance of programme boards and working groups;

(f) maintain an effective oversight of the performance and risks relating to the Berkshire West health and social care system.

(2) BWICP Executive – the current membership of this Group will need to be rationalised if it is to remain effective. The three Unitary Authority Chief Executives would join this Group along with the existing Chief Executives. It is proposed that each CEO would also be accompanied by one of their Directors. The Group would also contain the existing clinical representation and the Berkshire Strategic Director of Public Health. The independent Chair of the ICP Leadership Board would

also be invited to attend as an observer.

The Chair of the Executive would rotate between Health and Local Government.

The primary purpose of the Executive would be to;

(a) deliver and have oversight of the ICP programme taking management decisions where required to ensure strong performance;

(b) receive exception reports and an overall evaluation of progress with the ICP Programme from the ICP Delivery Group;

(c) consider reports from and issues arising from the BOB ICS including preparing responses to wider issues concerning the BOB ICS;

(d) provide clinical, professional and managerial leadership;

(e) prepare a quarterly report for the ICP Leadership Board with regard to overall performance across the Berkshire West health and social care system and for the Programme overall;

(f) approve the appointment, removal or replacement of programme and project management personnel.

(3) BWICP Delivery Group – the membership of the Delivery Group might need to be reviewed but this grouping already draws its membership from Health and Local Government across Berkshire West. Membership would primarily be drawn at the Director level alongside programme and project management resources. It is proposed that the Chair of the Delivery Group is drawn from the Executive membership and is from the sector which is not chairing the Executive at that time. The Chair would rotate at the same time as the Executive. The purpose of the BWICP Delivery Group would be;

(a) act as the Programme Board for the BW ICP. As such the Group will be responsible to the Executive for implementing the agreed programme of joint work;

(b) coordinate the allocation of resources to ensure that the Programme can be delivered;

(c) provide effective challenge and peer review in considering and approving PIDs and Business Cases relating to the Programme;

(d) review progress against the agreed critical success factors for the Programme which enable assurance of the expected impacts;

(e) on behalf of the Executive provide a quarterly report setting out performance of the Berkshire West health and social care system;

(f) maintain an overview of relevant activity across the three Localities providing support and co-ordination where appropriate;

(g) provide support where required to the BOB ICS in support of its work programme and related activity required across Berkshire West as agreed with the ICP Executive;

4.21 Fig.2 provides an overview of the governance arrangements which include;

(1) the linkages to System, Locality and Neighbourhood;

(2) the Programme Boards and Enabling Groups that are seen as necessary to take forward the ICPs strategic objectives for 2019/20.

Appendix 6 provides more detail on the membership of the Programme Boards and Delivery Groups that it is currently proposed will be in operation during 2019/20. (in preparation)

4.22 It will be important to ensure that the meetings of each of the main three Groups are managed effectively. This is likely to be less of an issue for the Delivery Group who will retain a health/local authority membership similar to that at present. The Executive will function with a similar representation to the current Chief Officers Group although it is also proposed that one Director from each partner organisation is also invited. This will therefore become a larger meeting.

4.23 The biggest change will be at the Leadership Board which has to date been almost entirely Health representation and with an agenda devoted entirely to the BWICS. With the advent of the BOB ICS this work programme will shift. It will also be increasingly influenced by the Localities and hopefully a greater emphasis on health and wellbeing and prevention. As important will be the change in membership. Elected Members with their local authority Chief Executives will join this meeting and it will be important to ensure that the agenda remains relevant to all.

4.24 The risk is that the future agenda of the Leadership Board is dominated by Health matters. The link to the BOB ICS is likely to reinforce this as is a focus on a Health dominated NHS LTP. The BW ICS Programme outlined in this Paper is itself Health dominated so there is a real danger of Local Authority officers and Members becoming spectators at the Leadership Board meeting. It is likely that the agenda will need to be managed accordingly with the potential to have a Part A meeting which involves Health and Local Authority partners meeting separately followed by a Part B meeting in which the Partners meet together to discuss issues of mutual interest. The agenda would need to be ordered appropriately.

4.25 The timing of the three meetings would need to be co-ordinated given that the Delivery Group needs to feed the Executive and the Executive, the Leadership Board. Links to the System and Locality governance also need to be considered.

5. Support Arrangements

5.1 A significant amount of project and programme management staffing resource is currently deployed to support the BWICS and BW10 Programme. This excludes senior management time which is spent in meetings supporting the existing governance. Taken together the current cost is likely to exceed £1m per annum.

5.2 The BWICS programme management team costs £105k (staffing costs only) and is supported by NHS Transformation Funding. This is linked directly to Berkshire West's status as an aspirant ICS. It is unclear at this point how the move to create

the ICS at BOB will change this but for the purposes of this report it has been assumed that this funding will continue.

5.3 The BW10 Programme Management Team costs are funded through the Better Care Fund (BCF). These funds are held by each of the three Local Authorities. The funding is used to fund a Berkshire West Programme Office and Project support in each of the Unitary Authorities. The costs are set out in Table 2 and total £730k per annum.

5.4 Given the bringing together of BW10 and BWICS it seems logical to now bring the Programme support together in one place. The new single Programme Office will be responsible for;

(1) programme management of the ICP's Transformation Programme with the allocation of appropriate project officer support to assist the Programme Boards and Delivery Groups;

(2) supporting the ICP governance including the preparation of a forward plan and agenda management including preparation, despatch and minute taking;

(3) performance management for the ICP including data collection, analysis and report preparation;

(4) liaison where appropriate with BOB ICS and Localities re HWBBs etc.

5.5 At this point it is proposed that the new single Programme office would comprise;

(1) Programme Manager;

(2) Administrative Assistant;

(3) Up to three Project Officers;

5.6 Further consideration needs to be given to the work programme before considering how many Project Officers are required. It is anticipated at this stage that the Programme Office will continue to be funded by a combination of NHSE Transformation and BCF Funding. It would seem appropriate to have the Programme Manager and administrative support based at the CCG Officers in Reading. The physical location of the Project Officers would be more flexible. They are likely to work at both a Place based and Locality level and would be located locally. Current estimates suggest that savings in staffing costs will be made in moving to the single ICP. These are likely to be within the ringfenced BCF budget.

6. Conclusions

6.1 The original objective of this Paper was to propose governance arrangements for a combined BW10 and BWICS Programme. There has been widespread acceptance that the two Programmes needed to be brought together however the publication of the NHS LTP in January this year has introduced a number of complications.

6.2 The future ICS seems unlikely to be based on Berkshire West but on BOB. A new taxonomy is now beginning to emerge based around BOB being seen as the System with Berkshire West, Oxon and Bucks each being designed as Place. In

addition to this the terms Locality and Neighbourhood have also been defined creating a hierarchy in the governance of health and social care. In many respects this new taxonomy is helpful and will hopefully lead to much needed clarity as to who is doing what and where. The BW10 would most probably have made greater progress if such clarity had been forthcoming in 2014.

6.3 Aside from the new taxonomy the new NHS LTP has also provided a set of themes which are being used more widely by the BOB STP to frame its own objectives. This has been continued in this Paper to provide some continuity.

6.4 The focus on the NHS LTP should however be treated with some caution. It is a NHS document seemingly written almost entirely for the NHS. It says little about Local Government, Public Health or the community and voluntary sector and therefore does little to embrace true health and social integration. The NHS LTP also brings significant new resources for the NHS over the medium term. At the time of writing the Government had yet to do anything to address the funding challenges in Social Care nor the ongoing reductions in Public Health Grant. A growing disparity in the funding positions of NHS and Local Government partners will not be conducive to productive joint working and integration and will require effective leadership.

6.5 All that said the NHS LTP shifts the emphasis from Berkshire West to BOB. NHS funding will now be channelled through the BOB ICS and it will be essential for Berkshire West to play a strong role within what seems likely to be a highly delegated system.

6.6 The proposal to create a Berkshire West ICP reflects this need to establish a strong link with the BOB ICS. The new governance seeks to take the best from the existing BWICS and BW10. Importantly the arrangements should reduce and certainly not increase the time commitments of senior managers which has become a major issue in recent years. The proposals set out in this Paper are also expected to lead to a reduction in staffing costs.

6.7 Importantly the new governance arrangements seek to establish a clear role for Elected Members and also establish closer links with Health and Wellbeing Boards. The new ICP will still have an agenda dominated by Health. This will in part be a reflection of the agenda driving by the BOB ICS which in turn will be driven by the NHS LTP. If the new ICP is to be truly a partnership between Health and Local Government then the blending of work streams and a recognition of the work to be done at Locality and Neighbourhood will be essential. Creating agendas and a debate that can properly engage all partners will be a real challenge. If participants become spectators to an alien, unfamiliar, and largely irrelevant debate they will soon depart.

6.8 The history of the BW10 and BWICS suggests that balancing transformation with organisational objectives and the day to day ‘business as usual’ activity will remain challenging. There will be a need for the ICP to have a view and perspective on the performance of the Berkshire West Health and social care system. At the same time it will need to ensure its own Programme of activity is being delivered and that all of the partners are playing their part in delivering it.

6.9 Berkshire West does not have a vision or strategic objectives which sit comfortably with the new world within which it now sits. Neither does the BOB ICS. It is

currently shaping its new strategy. The BWICP will need to do likewise. For the purposes of this document a working set of strategic objectives have been established on which the governance proposals in this Paper have been shaped. At the same time various assumptions have been made about what is best done at System, Place and Locality. At this point the strategic objectives largely reflect those of the BWICS, BW10 and Chief Officers Group. They have been framed within the seven themes of the NHS LTP and where appropriate are reflective of the emerging strategy being developed by the BOB ICS. By definition they will change and the BWICP governance, most notably the Programme Boards, will need to change to reflect it.

6.10 The bringing together of the current arrangements under a new BWICP will also necessitate the bringing together of the staff that will need to support and the Paper makes a number of proposals in this regard.

7. Recommendations

(1) The strategic objectives outlined in Table 4 are approved as the basis of the BWICSs work programme in 2019/20 noting that these are likely to change as a new strategy is developed.

(2) The taxonomy summarised in Fig 1 and further developed in Tables 1a-b is used to frame the governance arrangements for the BWICP.

(3) The governance structure as set out in Fig 2 is adopted for the new BW ICP.

(4) The terms of reference for the BWICP Leadership Board, BW10 Executive and BW10 Delivery Group as set out in Appendices 5a-c are agreed.

(5) The principles for resourcing the ICP as set out in the report are agreed.

Nick Carter

April 2019

Supporting Information

CQC – Reading System Review

Table 1a - Proposed allocation of roles and responsibilities between System and Place as proposed in the BOB STP

We have pulled out where the STP can play a stronger design and delivery role. As a minimum, we think the STP can play a system design role in care quality and outcomes; workforce; digital; and best use of resources. But there are options for a stronger role if desired.

NHS

Organisational priorities to move us from first to second column?

	Primary responsibility for design	Primary responsibility for delivery	Proposed STP role under current approach	How role *could* develop to something more ambitious if desired
1. Integrated Care	Place	Place	Coordinate/share good practice/ encourage collaboration.	Elements of system design and delivery (e.g. digital primary care) Ambition and accountability
	Much of STP LTP section to be developed at place and amalgamated. Some elements at STP			
2. Prevention & Inequalities	Place	Place	Coordinate/share good practice/encourage collaboration.	Elements of system design (e.g. related to population growth or border localities).
	STP LTP section to be developed at place and amalgamated			
3. Care Quality & Outcomes	**STP (or wider)**	Organisation	**System design, leave delivery to place/ organisation**	Possibly system delivery e.g. clinical support services Ambition and accountability
	LTP section to be developed at STP level and added to by organisations			
4. Workforce	**STP**	Organisations	**Some system design, leave delivery to place/organisation.**	System design e.g. shortages System delivery e.g. regional bank or leadership academy
	LTP section to developed at place and amalgamated/added to at STP			
5. Digital	**STP (or wider)**	Place & Organisations	**System design, leave delivery to place/ organisation**	System delivery provider for all organisations
	LTP section to be developed at STP level and added to by places/orgs			
6. Efficiency	**STP**	Organisations	**Some system design, leave delivery to place/organisation**	System design – STP efficiency plan System delivery – for scale
	LTP section to be developed in place and amalgamated/added to at STP			
7. Engagement & Partnerships	Place	Place	Coordinate/share good practice/ encourage collaboration.	System design on engagement, especially with big employers/ housebuilders
	LTP section to be developed in place and amalgamated/added to at STP			

25

Table 1b – Proposed allocation of roles and responsibilities between Place and Locality

LTP Theme	Primary responsibility for design	Primary responsibility for delivery	Notes
1. **Integrated Care**			
Primary Care Networkers	Locality	Neighbourhood with oversight from Locality	
Joint Commissioning	Place	Place and organisations	
Population Health Management	Locality	Locality with oversight from Place	
Urgent and Emergency Care	Place	Place and Organisations	Effective governance already in place
Personalised care; • Personal health budgets • Social prescribing	Place Locality	Neighbourhoods with oversight of Locality	
2. Prevention and Inequalities			
• Smoking • Alcohol • Obesity • Antimicrobial resistance • Air Pollution • Health inequalities	Place Locality	Place Locality	

LTP Theme	Primary responsibility for design	Primary responsibility for delivery	Notes
3. Care Quality and Outcomes			
• Maternity and neo natal • CYP • Cancer • Cardiovascular • Stroke • Diabetes • Respiratory • Adult Mental Health • Short waits for planned care • Research and innovation	Place	Place	System will have a role in design as well
4. Workforce			
• Recruitment • Retention • Productivity • Leadership and management • Volunteers	Place	Place/organisation	Same design by system
5. Digital			
• Empowering people • Supporting professionals • Supporting clinical care • Improving population health • Improving efficiency/safety	Place	Place/organisation	Design is currently largely seen to be at system level

LTP Theme	Primary responsibility for design	Primary responsibility for delivery	Notes
6. Efficiency			
• Cash releasing productivity • Procurement • Pathology • Estates etc • Reducing variation • Capital	Place	Place/organisation	Efficiency Plan will also be produced at system level for working at scale
7. Engagement and Partnerships	Locality/ Neighbourhood	Locality/Neighbourhood with some 'light touch' coordination at Place if needed	Engagement and partnership activity will be driven at Locality and Neighbourhood level
8. ICP Strategy			
• Development of an ICP strategy to incorporate the Health and Wellbeing Strategy	Locality	Locality	Strategy will be bought together at Place and will reflect where appropriate system strategy

Table 2 – Current Programme Management Costs for the BW10 and BWICS

1. BWICS (source NHS Transformation Funding)

Staffing	-	£105k
Other	-	£unknown
Total		£105k

2. BW10 (source: BCF)

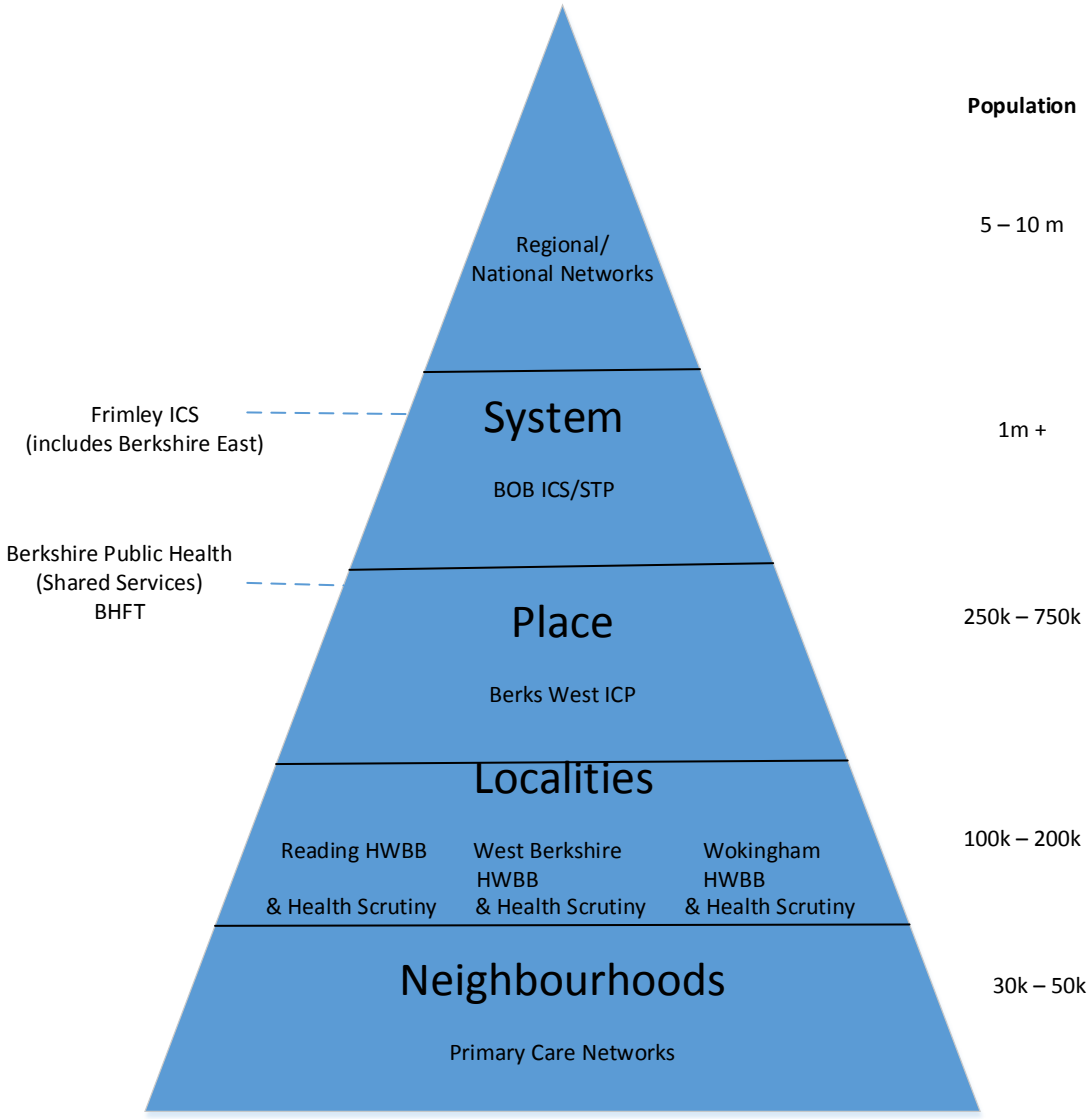
Berkshire West – Programme	£181	
Projects		£169
Reading Programme Office		£150
West Berkshire Programme Office		£100
Wokingham Programme Office		£130
Total		£730

Table 3 - Proposed Berkshire West Place based activity during 2019/20

Place based objectives

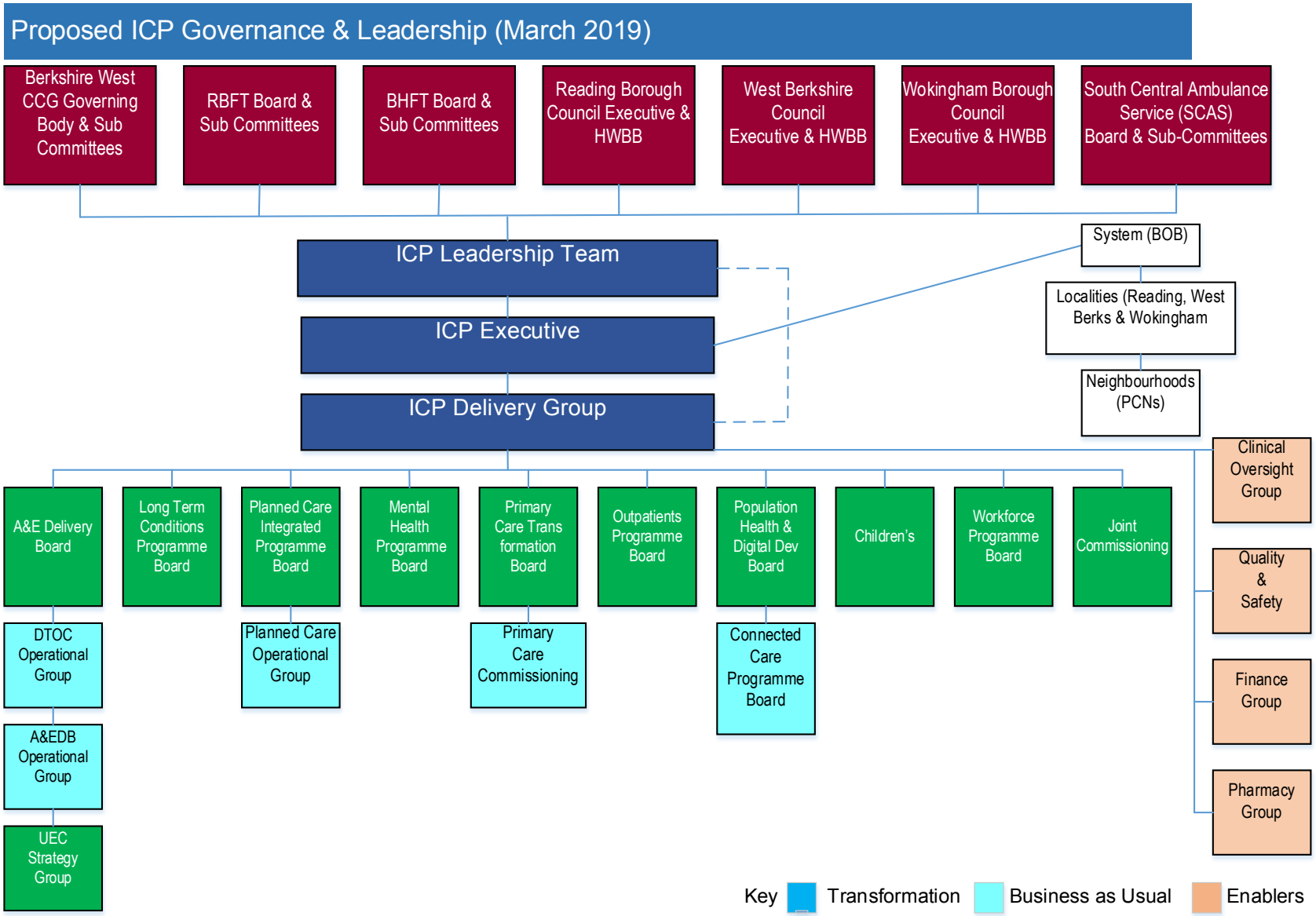
1. An improvement in the health and wellbeing of our population
2. Enhancement of patient experience and outcomes
3. Financial sustainability for all constituent organisations

Fig. 1 – The proposed Health and Social Care Planning Taxonomy on which Berkshire West governance is based

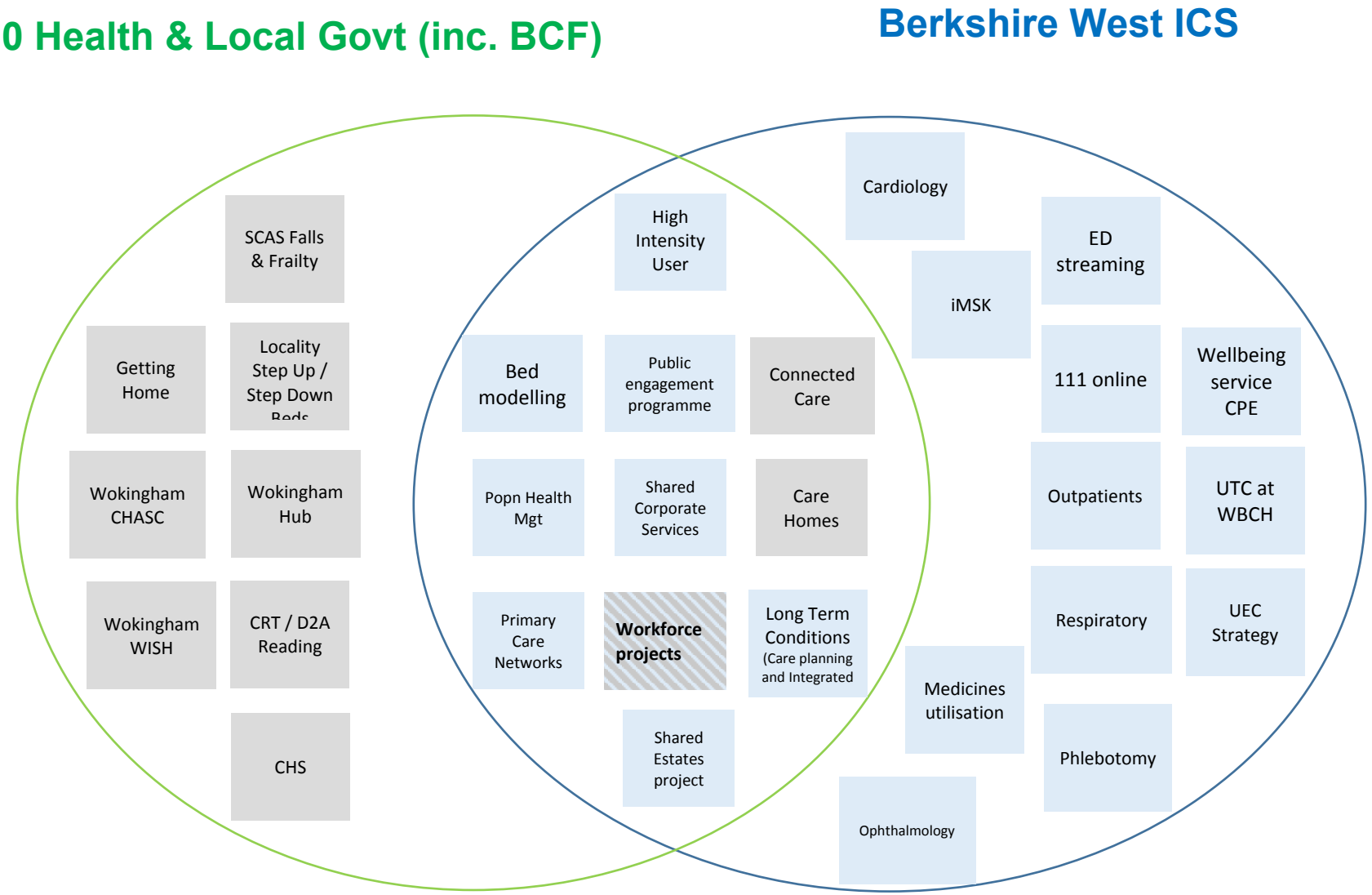


Note: Delivery will also be provided by organisations which will not necessarily align with this taxonomy

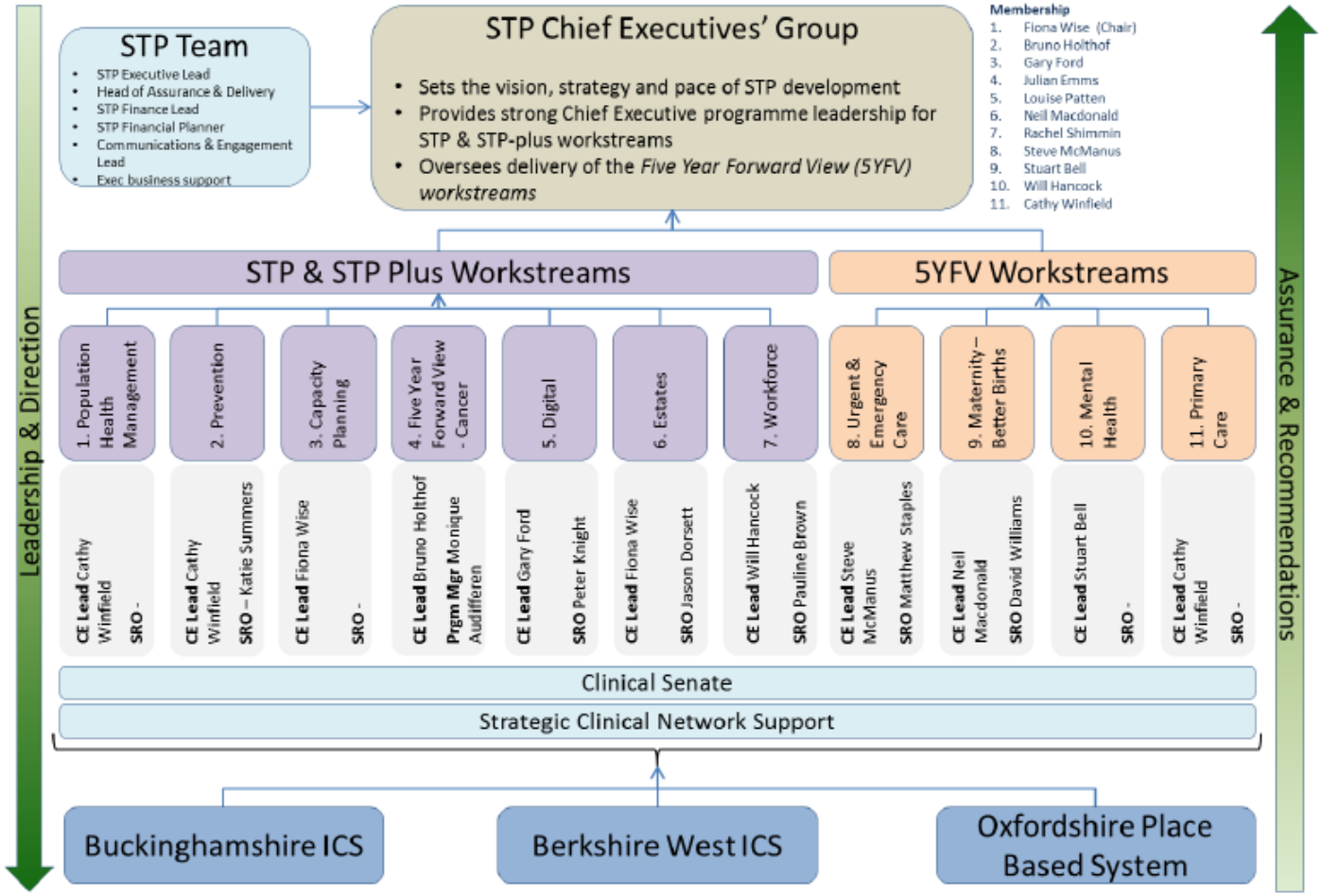
Fig 2 – Proposed BWICP Governance Structure



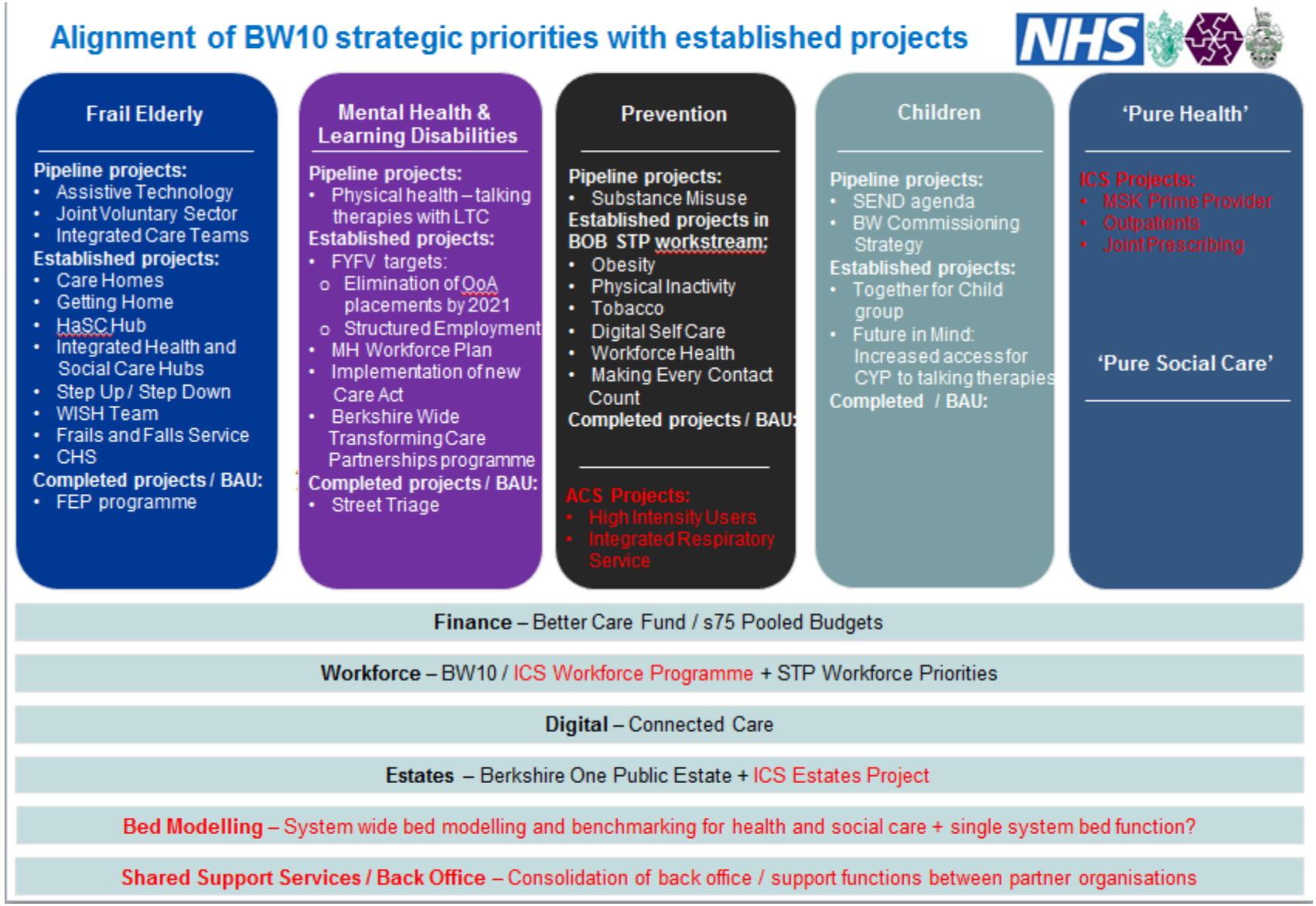
Appendix 1 – BW10 and BW10 ICS - Roles & Responsibilities and areas of common interest



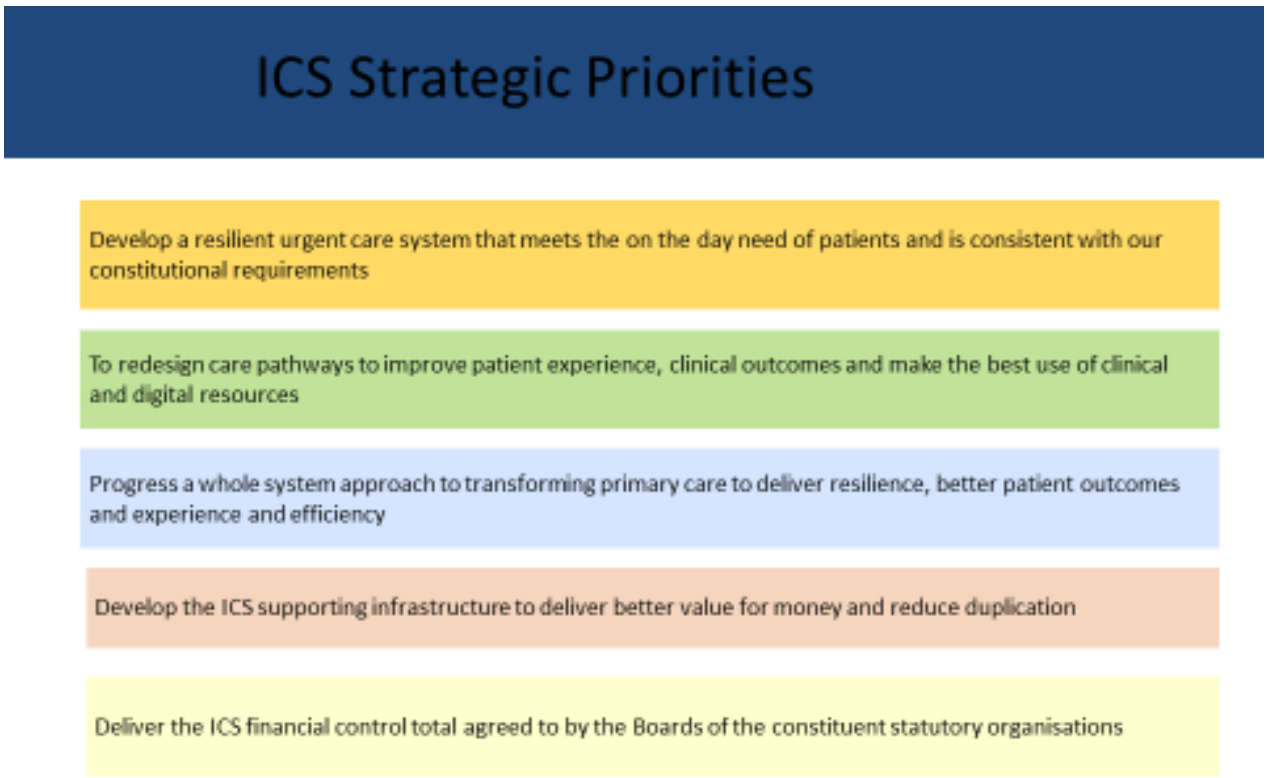
Appendix 2 – BOB STP Governance Chart – November 2018



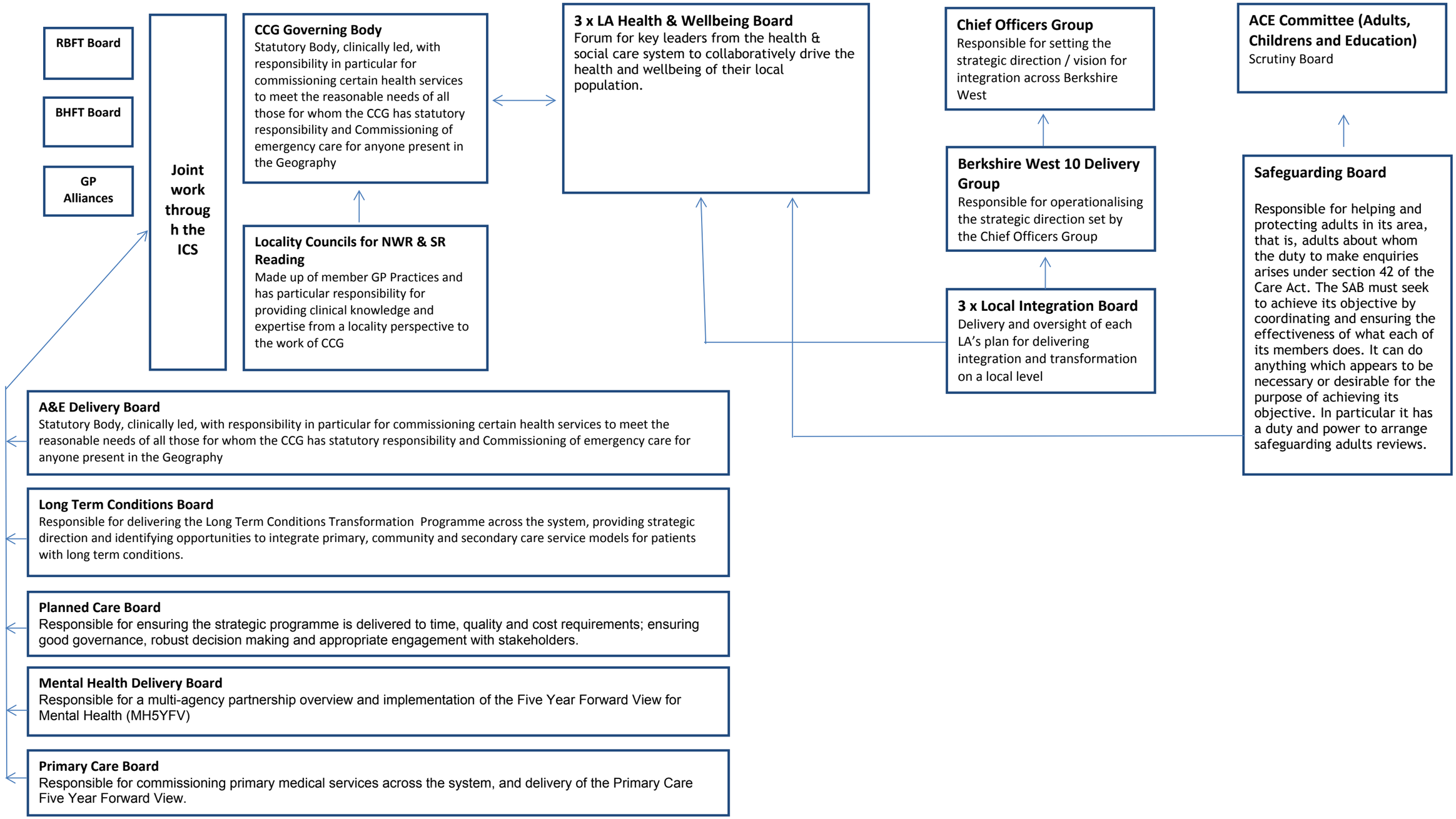
Appendix 3a – The Vision Framework for Berkshire West 10 (October 2018)



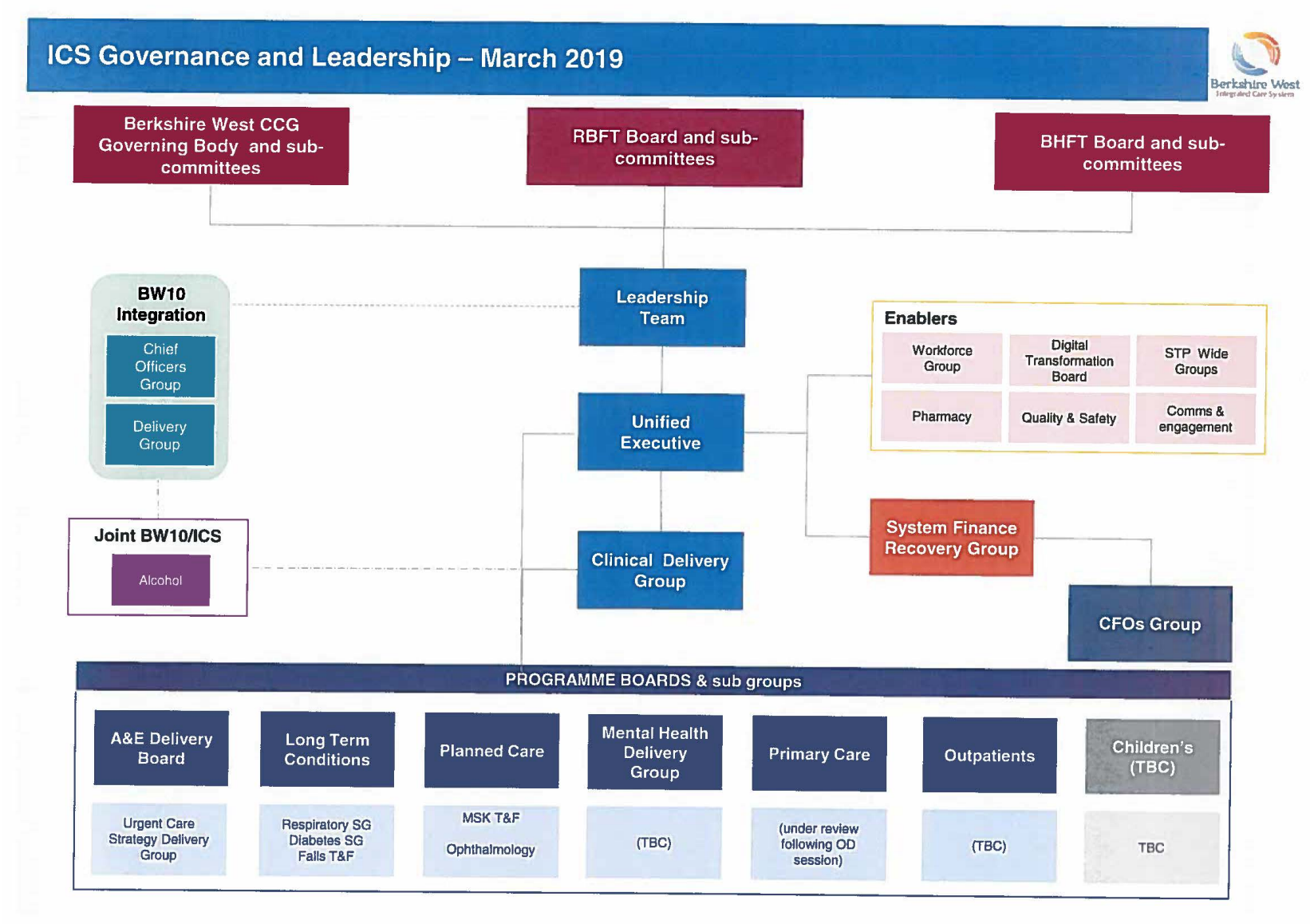
Appendix 3b – The Strategic Priorities of the Berkshire West ICS



Appendix 4a – Health & Social Care Governance Arrangements for BWI0



Appendix 4b – Governance arrangements for BWICS



Appendix 5a – Proposed ToR

Berkshire West ICP Leadership Board

Terms of Reference

1 Scope

1.1 The ICP Leadership Board will be responsible for leading the development of the ICP strategy and oversee delivery of the ICP programme aligned as required to the BOB ICS Strategy.

2 Standing

2.1 The meeting of the ICP Leadership Board provides the vehicle for the partners to work as a single partnership. The current sovereignty of the participating organisations is unaffected; however, members of the Leadership Board will be expected to act in accordance with the responsibilities which are vested in them through being Members of the Board.

3 General Responsibilities of the Leadership Team

3.1 The general responsibilities of the ICP Leadership Board are:

(a) to formulate, agree and implement a strategy for the Berkshire West ICP (BWICP) which delivers the objective of stated objectives of the ICP.

(b) to ensure alignment of all partners to the Berkshire West ICP strategy

(c) to promote and encourage commitment to the principles and strategic priorities

(d) to ensure that Berkshire West is effectively represented within the BOB ICS

(a) to seek to determine or resolve any matter referred to it by the Executive or any individual party; and

(b) the review of the performance of the partners within the Berkshire West ICP Memorandum of Understanding and determining interventions to improve performance or rectify poor performance – recommending remedial and mitigating actions across the system;

(c) review and approve the BWICP programme governance at appropriate intervals

4 Independent Chair / Programme Director / Programme Manager

4.1 An independent non-voting chair has been appointed by the partners to oversee the Leadership Board.

5 Members and Alternate Members of the Leadership Board

5.1 The following will be the Leadership Members:

(a) the current Chief Executive and Chair of RBFT;

(b) the current Chief Executive and Chair of BHFT;

(c) the Berkshire West CCG Federation Chair and Accountable Officer.

(d) the Managing Director and an Executive Member from Reading Borough Council

(e) the Chief Executive and an Executive Member of West Berkshire Council

(f) the Chief Executive and an Executive Member from Wokingham Borough Council

(g) the independent chair of the ACS

(h) Two GPs who represent a minimum of two GP Provider alliances from within the Berkshire West system.

5.2 An appropriate deputy may be appointed to attend a meeting on behalf of one of the members

5.3 The partners will each ensure that, except for urgent or unavoidable reasons, their respective member (or their appointed deputy) attends and fully participates in all of the meetings of the BWICP Leadership Board.

5.4 No matter will be recommended at any meeting unless a quorum is present. A quorum will not be present unless at least one ACS Leadership Board Member from BHFT, RBFT, GP providers, the three local authorities and the CCG Leadership Board members are in attendance.

5.5 The following will be the non-voting Leadership Board members:

- The BWICP Programme Manager

6 Proceedings of Leadership Board

6.1 The Leadership Board will meet on a bi-monthly basis and may call extraordinary meetings as required

6.2 If unavoidable, members may join by telephone conference or video link by exception.

6.3 Each Leadership Board member will have an equal say in discussions and will look to agree recommendations on the basis of the Principles of collaboration (attached).

7 Attendance of third parties at Leadership Board meetings

7.1 The Leadership Board shall be entitled to invite any person to attend but not take part in making recommendations at meetings of the Leadership Board.

8 Administration for the Leadership Board

8.1 Papers for each meeting will be sent to Leadership Board members no later than five days prior to each meeting by the Programme Manager via the Chair. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting. Every effort will be made to circulate papers to Leadership Board members earlier if possible

8.2 The minutes of the ICP Executive meeting will be made available to the ICP Leadership Board on a monthly basis

8.3 Minutes, or where considered appropriate, the action points of the Leadership Board meetings will be circulated to all Leadership Board members as soon as reasonably practical.

9 Review

9.1 The Leadership Board will review these Terms of Reference annually.

(Need to agree a position on this)

Appendix A - Principles of Collaboration (extract from the Berkshire West ACS MoU)

1.1 The Parties agree to adopt the following principles when carrying out the development of the Accountable Care System (the "**Principles**"):

1.1.1 address the vision. In developing the Accountable Care System the Parties seek to address the triple aims of the Forward View: increasing the emphasis on primary prevention, health and wellbeing; improving quality of care by improving outcomes and experience for patients and achieving constitutional standards; delivering best value for the taxpayer and operating a financially sustainable system;

1.1.2 collaborate and co-operate. Establish and adhere to the governance structure set out in this MoU to ensure that activities are delivered and actions taken as required to deliver change collectively and in partnership with the three Berkshire West local authorities and the wider NHS ;

1.1.3 be accountable. Take on, manage and account to each other, the local authorities, the wider NHS and the Berkshire West population for performance of the respective roles and responsibilities set out in this MoU;

1.1.4 be open. Communicate openly about major concerns, issues or opportunities relating to the Accountable Care System and be transparent adopting an open book approach wherever possible (acknowledging the Parties requirements under paragraph 4.1.5 below);

1.1.5 adhere to statutory requirements and best practice. Comply with applicable laws and standards including procurement rules, competition law, data protection, information governance and freedom of information legislation;

1.1.6 act in a timely manner. Recognise the time-critical nature of the Accountable Care System and respond accordingly to requests for support;

1.1.7 manage stakeholders effectively with a clear intention to engage with all relevant stakeholders in the development of the Accountable Care System and to look towards the future inclusion of social care and the local authorities as parties to the arrangements;

1.1.8 deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this MoU; and

1.1.9 act in good faith to support achievement of the Key Objectives and compliance with these Principles and to develop appropriate "Rules of Engagement" between stakeholders in the Accountable Care System

Proposed amendments to ICS Leadership Group Terms of Reference

Timing

- The Leadership Board should meet six times per year 2 weeks after the Executive; the Chair to determine agenda in collaboration with the Programme Manager.
- Meeting dates to be agreed annually.
- Meetings should be scheduled for two hours each.
- The ACS Chairs will meet in intervening months for an informal catch-up and alignment discussion

Pre-read and interim-read

- Executive minutes to be copied to LG members. This is for information/context only and should not repeat/over-lap with papers for the LG.

Attendees

- As per proposal except;
    - Only "minute-taker" and Programme director needed to support every meeting.
    - Any external/mgt. group contributors should attend only for their discussion and only with prior approval from the Chair.
    - One GP provider representative as a permanent and consistent attendee
    - Quorum – at least one representative from all of BH, RB, CCG, GP and Chair make LG quorate, with Chair able to nominate his replacement in event of unavoidable absence.

Scope and philosophy

- The ICS Leadership Group (LG) represents all parties constructed within the ICS framework and within the scope of the MoU. It is instrumental in developing and implementing the BWICS strategy.
- LG will consider the capacity, resources, transformation, operations and reputation of, and risks to, the BWICS as a whole relation to agreed strategy and the wider system as a whole. As such it (LG) will endeavour to ensure cohesion, integration and collegiate working practices and behaviours to deliver the strategy and objectives of the BWICS and amongst providers, commissioners and work-groups.
- Under no circumstances should the LG concern itself with day to day operations. Subsidiarity should apply albeit with the joint rights to challenge a decision if it is felt by other members that a wider intervention/opportunity is possible.
- All members of the LG should focus solely on “full width" ICS matters - strategy, transformation and delivery. It should focus on and be prepared to act together to intervene on unambitious, slow or weak performance where a risk to the BWICS is identified by the Chair.
- A mantra might be that, we all leave our organisation out of the room when we come in.
- Support proposals which benefit the whole system, where there is agreed evidence that the proposal will materially improve the care of patients achievable within available funding for the whole BWICS. Where changes necessary to meet an improvement to BWICS is a detriment to

one provider, the members agree to identify mitigations in an equitable way through an agreed risk share.
- The Chair must be willing to meet key stakeholders and regulators on a regular basis to support our ambitions and promote external relations, including contact with other similar bodies and those representing ICS objectives.

LG primary purpose and responsibilities

- **Act** to optimise the Berkshire West health and social care system in delivering better care for patients with increased cost effectiveness.
- **Concentrate** on the creation of strategy, building confidence with all partners, approval of key efficiency programmes, resolution of strategic blockers, delegation to executives for implementation and direct challenge where there is under delivery/performance.
- **Lead** the development and articulation of the ICS' strategy and oversee delivery of programmes and commitments.
- **Ensure** delivery of the requirements set out in the MoU agreed between the BWICS leaders and NHSE/I.
- **Create** a shared understanding of the 'vision' and 'end point' for the ICS and ensure this is aligned with the Principles and objectives.
- **Intervene** robustly to address shortfall in delivery and performance of mgt groups, work-streams for individual members of BWICS.

Appendix 5b – Proposed ToR

Berkshire West ICP Executive

Terms of Reference

1 Scope

1.1 The Executive will be responsible for the day to day leadership, management and support of the activities of the BWICP work programme of the Executive is to have a tactical level of detail, ensuring processes are in place to support high quality outcomes for services and the population of Berkshire West.

2 Standing

2.1 The meeting of the Executive provides the vehicle for the Partners to work as a singe alliance. The current sovereignty of these organisations is unaffected; however, members of the Executive will be expected to act in accordance with the responsibilities which are vested in them by virtue of their formal roles within their organisations.

3 General Responsibilities of the ICP Executive

3.1 The general responsibilities of the Executive are:

(a) to deliver and have oversight of the BWICP programme, taking management decisions where required to ensure strong performance
(b) monitoring the achievement of the objectives and receiving reports from the ICP Delivery Group on progress in the development of the ICP work programme.
(c) to manage and have oversight of the use of the nationally allocated Transformation Fund and to have oversight of the Better Care Fund (BCF)
(d) providing clinical, professional and managerial leadership with regard to the services
(e) ensuring compliance with the governance regime and leading the parties behaviour in accordance with the principles of the BWICP
(f) approve the appointment, removal or replacement of programme management

4 Reviews/Reporting

4.1 The ICP Delivery Group streams will report to the Executive and the Executive may request that SROs of the agreed attend Executive meetings where appropriate.

5 Members and Alternate Members of the Executive Team

5.1 Each partner will appoint and will at all times maintain one Executive member(s) on the Executive

5.2 The Executive Members will be

(a) Chief Officer of Berkshire West CCG

(b) Chief Executive and one Director from the Royal Berkshire Foundation Trust

(c) Chief Executive and one Director from Berkshire Healthcare Foundation Trust

(d) Chair of the ACS Clinical Strategy Group

(e) Managing Director and one other Director from Reading Borough Council

(f) Chief Executive and one Director from West Berkshire Council

(g) Chief Executive and one Director from Wokingham Borough Council

(h) Strategic Director for Public Health (Berkshire)

(i) BWICP Programme Manager

(j) Any two GP members of the four GP provider alliances.

5.3 An appropriate deputy may be appointed to attend a meeting on behalf of one of the members

5.4 The Partners will ensure that, except for urgent or unavoidable reasons, their respective Executive member (or their appointed alternative) attends and fully participates in all of the meetings of the Executive.

5.5 No matter will be recommended at any meeting unless a quorum is present. A quorum will not be present unless at least one (1) Executive Team Member from BHFT, RBFT, GP providers and the CCG Leadership Board members are in attendance.

5.6 The following will be non voting members of the Executive

5.7 The following will be the non-voting Leadership Board members:

- The ACS Programme Manager
- NHS England's 'Sponsor for the Berkshire West ACS who will attend on a regular basis when appropriate.

6 Proceedings of Executive Meetings

6.1 The Executive members shall agree and appoint a unified Executive Team member (or in his absence his Alternate Executive Team member) to be the chairman of the Executive Team (the "Executive Team Chairman")

6.2 If unavoidable members may joint by telephone conference or video link by exception

6.3 Each Executive Team member (or its alternate) will have an equal say in discussions and will look to agree recommendations on the basis of the Principles.

7 Attendance of third parties at Executive Team meetings

7.1 The Executive Team may invite any person to attend but not make recommendations at meetings of the Executive Team.

8 Administration for the Executive Team

8.1 Papers for each meeting will be sent to Executive Team members no later than five days prior to each meeting by the Programme Manager via the Chair. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting. Every effort will be made to circulate papers to Leadership Board members earlier if possible

8.2 The minutes of the Executive Team meeting will be made available to the Executive Team members as soon as reasonably practicable

8.3 Minutes, or where considered appropriate, the action points of the Leadership Board meetings will be circulated to all Leadership Board members as soon as reasonably practical.

9 Review

9.1 The Executive Team will review these Terms of Reference annually.

Appendix A - Principles of Collaboration (extract from the Berkshire West ACS MoU)

1.2 The Parties agree to adopt the following principles when carrying out the development of the Accountable Care System (the "**Principles**"):

1.2.1 address the vision. In developing the Accountable Care System the Parties seek to address the triple aims of the Forward View: increasing the emphasis on primary prevention, health and wellbeing; improving quality of care by improving outcomes and experience for patients and achieving constitutional standards; delivering best value for the taxpayer and operating a financially sustainable system;

1.2.2 collaborate and co-operate. Establish and adhere to the governance structure set out in this MoU to ensure that activities are delivered and actions taken as required to deliver change collectively and in partnership with the three Berkshire West local authorities and the wider NHS ;

1.2.3 be accountable. Take on, manage and account to each other, the local authorities, the wider NHS and the Berkshire West population for performance of the respective roles and responsibilities set out in this MoU;

1.2.4 be open. Communicate openly about major concerns, issues or opportunities relating to the Accountable Care System and be transparent adopting an open book approach wherever possible (acknowledging the Parties requirements under paragraph 4.1.5 below);

1.2.5 adhere to statutory requirements and best practice. Comply with applicable laws and standards including procurement rules, competition law, data protection, information governance and freedom of information legislation;

1.2.6 act in a timely manner. Recognise the time-critical nature of the Accountable Care System and respond accordingly to requests for support;

1.2.7 manage stakeholders effectively with a clear intention to engage with all relevant stakeholders in the development of the Accountable Care System and to look towards the future inclusion of social care and the local authorities as parties to the arrangements;

1.2.8 deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this MoU; and

1.2.9 act in good faith to support achievement of the Key Objectives and compliance with these Principles and to develop appropriate "Rules of Engagement" between stakeholders in the Accountable Care System

Appendix 5c – Proposed ToR -

Berkshire West ICP Delivery Group

Terms of Reference

1. Scope

The ICP Delivery Group will have programme management of the ICP work programme. It will report to the BWICP Executive primarily in the form of exception reporting. The Group will oversee where appropriate the work of the Programme Boards and supporting groups. The Delivery Group has a key co-ordinating role within the ICP governance.

2. Standing

The meeting of the ICP Delivery Group provides the vehicle for the partners to work as a single partnership and to coordinate work across the whole ICP.

3. General responsibilities of the Delivery Group

3.1 The general responsibilities of the ICP Delivery Group are;

(a) Act as a Programme Board with regard to the ICP. As such the ICP DG will be responsible for overseeing the implementation of actions focussed on the delivery of the BWICP objectives and in support of the BOB ICS

(b) Co-ordinate the allocation of resources to ensure that the IIP work programme can be delivered

(c) Provide effective challenge and peer review in considering and approving PIDS and business cases relating to projects and schemes relevant to the work programme.

(d) Review progress against the critical success factors and put in place appropriate performance management arrangements which enable assurance of expected impact.

(e) Review the governance arrangements for the ICP as required and to act as custodian and guardian of them to ensure that governance and decision making arrangements are consistent and effective.

(f) Prepare a regular review of the Berkshire West system performance for consideration both by the BW ICP Executive and the BW ICP Leadership Board.

(g) Provide assurance to the Executive on progress highlighting any risks and issues.

(h) The BW ICP DG will amend the ICP work programme as programmes, resources and strategies dictate.

4. Members and Alternate Members of the Delivery Group

4.1 The following will be the Delivery Group Members

- Directors of strategy with the NHS
- Directors of Adult Social Services and Directors of Children's Services
- Programme Board Chairs and the Chairs of other supporting groups
- The SOPH or his/her Deputy

4.2 An appropriate deputy may be appointed to attend a meeting on behalf of one of the Members.

4.3 The BWICP DG will be chaired by the Chief Executive from the BWICP Executive. The Chief Executive will be drawn from the sector (NHS or local government) that is not chairing the BWICP Executive. The Chair will rotate annually as at the BWICP Executive.

4.4 The partners will each ensure that, except for urgent or unavoidable reasons, their respective Member/or appointed deputy) attends and fully participates in all of the meetings of the BWICP Delivery Group.

5. Proceedings of the Delivery Group

5.1 The Group will meet on a monthly/bi-monthly basis and may call extraordinary meetings as required.

5.2 If unavailable, Members may join by telephone conference or video link by exception.

5.3 Each Delivery Group member will have an equal say in discussions and will look to agree recommendation on the basis of the Principles of Collaboration (attached).

6. Attendance of third parties at Delivery Group meetings

6.1 The Delivery Group shall be entitled to invite any person to attend but not take part in making any recommendations at meetings of the Delivery Group.

7. Administration for the Delivery Group

7.1 Papers for each meeting will be sent to Delivery Group members by the ICP Programme Office no later than five days prior to each meeting. The agenda and papers will have previously been agreed by the Chair. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting. Every effect will be made to circulate papers to Delivery Group members earlier if possible.

7.2 Minutes and action points of the Delivery Group meetings will be circulated to all Delivery Group members as soon as reasonably practical.

8. Review

8.1 The Delivery Group will review these Terms of Reference annually.