NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

BOARD MEETING

Date of Meeting: 21 March 2023	**Agenda item:** 10

Title of Paper: Place-Based Partnership Development Update

Paper is for: (Please ✓)	**Discussion**		**Decision**		**Information**	

Executive Summary

This paper outlines progress on the development of Place-Based Partnerships within the Buckinghamshire, Oxfordshire, and Berkshire West ICS (BOB ICS) and some of the enablers that system partners are working through to best support effective integration at Place.

The paper outlines examples of service delivery supported by partnership working in 2022/23, priorities for 2023/24 and enablers including:

- A maturity matrix against which we can self-assess our Partnerships.
- An overview of potential governance structures that could be adopted to enable functional Place delegation and integration.
- A summary of deliverables and milestones for ongoing Place-based Partnership development.

The key principles that the board are asked to endorse through this paper are:

- The importance of place-based partnerships in supporting the objectives and strategies of the Integrated Care Partnership (ICP), Integrated Care System (ICS) and Integrated Care Board (ICB).
- That support for place-based partnerships will operate through a form follows function principle and the ICB will not dictate specific governance and delegation models but look to work with partners on models that best meet local need.
- That the ICB will commit management resource and subject matter expertise to support both the development of and delivery through place-based partnerships.
- That provider collaboratives and place-based partnerships need to work closely together to ensure we maximise the service impact and population health outcomes improvements of these new models.

Action Required

The board are asked to:

- Endorse the key principles outlined.
- Note the progress made in 2022/23 and emerging 2023/24 priorities in terms of service improvement and delivery.
- Note the potential range of governance arrangements and agree that local variation may be required as partnership arrangements develop and mature.
- Note and comment on the broader enabling work outlined in the paper.

Date and Name of Committee/meeting at which Paper Reviewed: The development of this paper was informed by discussion at Place and System Development Committee and the Executive Management Committee.

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Date of Paper: 7 March 2023

Conflicts of Interest	
Board partner members are likely to be members of place-based partnerships. The perspective of these members is an important aspect to development of our ways of working and governance arrangements.	
No conflict identified	
Conflict noted: conflicted party can participate in discussion and decision	✓
Conflict noted, conflicted party can participate in discussion but not decision	
Conflict noted, conflicted party can remain but not participate in discussion	
Conflict noted, supported paper withheld from conflicted party e.g. pecuniary benefit	
Conflicted party is excluded from discussion	

PLACE-BASED PARTNERSHIP DEVELOPMENT UPDATE

Introduction

1. Integrated care systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. The purpose of ICSs is to bring partner organisations together and embrace opportunities to deliver at scale, with an expectation in national policy that systems will work through sub-system geographies call 'Places.' The Integrated Care Board has a range of statutory functions and responsibilities in its own right within the ICS.

2. The key principles that the board are asked to endorse through this paper are:
   - The importance of place-based partnerships in supporting the objectives and strategies of the Integrated Care Partnership (ICP), Integrated Care System (ICS) and Integrated Care Board (ICB).
   - That support for place-based partnerships will operate through a form follows function principle and the ICB will not dictate specific governance and delegation models but look to work with partners on models that best meet local need.
   - That the ICB will commit management resource and subject matter expertise to support both the development of and delivery through place-based partnerships.
   - That provider collaboratives and place-based partnerships need to work closely together to ensure we maximise the service impact and population health outcomes improvements of these new models.

3. This paper focusses on the development of Place-based Partnerships within the Buckinghamshire, Oxfordshire, and Berkshire West (BOB ICS) and makes the following key points:

   i. All three Places have multiple partnership forums to bring together Place leadership which are delivering tangible benefits for our residents. These partnerships are currently informal arrangements convened through mutual agreement, with some pooled/aligned resources (e.g., Better Care Fund (BCF) and other s75 pooled budgets). Work is ongoing to build upon and strengthen these partnership arrangements.

   ii. We are recommending that 'form follows function,' with individual programmes of work determining the most appropriate formal delegation arrangements that will result in the best outcomes for our population and the best use of resources. These arrangements may be at Place, through Provider Collaboratives, or delivered at a system level.

   iii. In the meantime, an ICB Operating Model will be adopted where some programmes of work are managed at Place and others are managed across the BOB System, with a proposed designation included in this paper. Where a programme of work is managed at Place, 'ownership' of ICB responsibilities and accountabilities will be via Place Director executive accountability with support from the wider ICB Executive Team.

Developing our Place-Based Partnerships

4. BOB ICS has 3 strong and distinct 'Places' – Buckinghamshire, Oxfordshire, and Berkshire West. These are based on previous CCG boundaries, broadly aligned with the catchment for district general hospital services (but population based) and are aligned with local authority geographies. Place-Based Partnerships (PBPs) are an important local focus within the ICS, designed to 'lead the detailed design and delivery of integrated services across their localities and neighbourhoods[1].

5. BOB's three Places have varying Partnership arrangements, but all now have forums (whether formal or informal) to bring together Place Leadership including Chief Executives from the main NHS providers, Chief Executives from Local Authorities (LAs) and representatives of District and City Councils (where applicable), Leaders from General Practice, and the BOB ICB.

[1] https://www.england.nhs.uk/integratedcare/what-is-integrated-care/

6. Examples of effective Place working that has already delivered tangible benefits to our population include:

- **Oxfordshire:** Over winter 22/23, secondary care, mental health and community care, social care and primary care providers worked closely to deliver integrated urgent care services such as virtual wards, transfer of care team (integrated discharge) and other community and home-based care design to avoid unnecessary hospital visits. Some of the impacts included:
  - 55 additional winter beds in the community.
  - Additional surge and escalation capacity across four Oxford University Hospital sites.
  - Increased workforce for hospital at home.
  - 50% increase in referrals from South Central Ambulance Service to Urgent Community Responses.
  - The establishment of a City Urgent Care Centre (based at the John Radcliffe site) to offer same day primary care and reduce Emergency Department (ED) demand.
  - Focus on reducing conveyances from Care Homes to ED resulted in an average of 7 admissions compared to an average in 2019 of 20.
- **Berkshire West**: Throughout the ongoing COVID-19 Vaccination Programme, integrated ways of working at Place have been central to our approach in addressing inequalities in vaccination take up. In Berkshire West we held a fortnightly multi-agency place-based coordination meeting, the Vaccine Action Group chaired by a Local Authority CEO, which provided oversight across the whole programme and its sub-group, the Vaccine Inequalities Group. The Vaccine Inequalities group developed a plan to identify communities at risk of health inequalities and of lower levels of vaccine take up. It also designed engagement-led approaches to working with community leaders to address underlying causes of low vaccine confidence and provided opportunities to localise vaccine delivery through outreach clinics and health on the move van, with more than 50 Health on the Move Van events running with each relying on an integrated team including our three LAs, Royal Berkshire Foundation Trust, Berkshire Healthcare Foundation Trust, Oxford Health, BOB colleagues and voluntary sector partners to organise and advertise events.
- **Buckinghamshire**: In recent years different partners across Buckinghamshire have been working together effectively to address some of the significant challenges the system has faced, not least the challenge of the COVID-19 pandemic, which necessitated strong partnership working and effective decision making across health and care. More recently, partners have built on this to come together to tackle the challenge of improving discharge and flow across health and social care, and an integrated joint programme has been established across the Council, Buckinghamshire Healthcare Trust and the ICB to respond to the challenges of increasing demand and acuity in Buckinghamshire. Partners are working together to deliver the Opportunity Bucks programme which is targeting the ten most deprived wards in the county and seeking to develop interventions to level up health and wellbeing and address the wider determinants of health. There is also a strong programme of work underway to transform the way Special Educational Need and Disabilities (SEND) services are delivered in Buckinghamshire, which looks across integrated therapies delivered in educational settings, community paediatrics and support for those awaiting assessment for neuro-developmental conditions.

Emerging Priorities for 2023/24

7. The leadership of our PBPs are in the process of creating a clear, shared vision and identifying a set of priorities to support delivery of the Integrated Care Strategy and Health and Wellbeing Strategies in Places. Place-based Partnerships will provide a steer on how to prioritise and focus efforts to make the biggest impact on issues that can only be addressed if the majority of parties work together.

8. The **Buckinghamshire Executive Partnership** will build on agreed BCF Priorities for 2022/23 that have been shaped by the Joint Health and Wellbeing Strategy and the Integrated Care Partnership. The priorities are:
   - Hospital discharge
   - Admission avoidance
   - Mental health
   - Primary care community services and
   - Health inequalities with a focus on cardio-vascular disease.

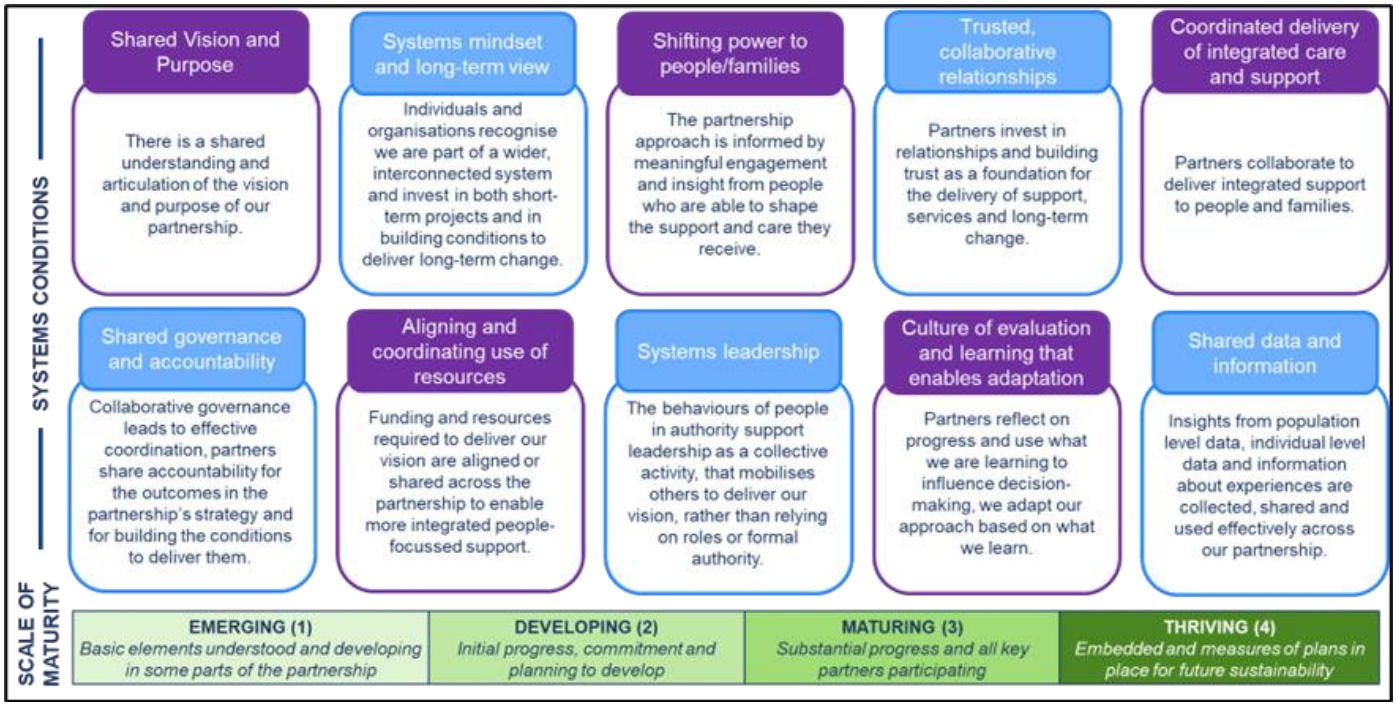
   Areas such as children's services have been suggested as possible additional areas of focus. The content of the work of the PBP will be subject to review and a workplan will be agreed on an annual basis.
9. Discussions at the **Oxfordshire Place-Based Partnership** have thus far focused on the following four service areas:
   - Children and Young People including school readiness, Child and Adolescent Mental Health, Learning Disability and neurodiversity.
   - Working Age Adults Mental Health and Wellbeing including LD and neurodiversity.
   - People with Urgent Care Needs including children, adults and older adults with multiple illnesses and frailty.
   - Health Inequalities and Prevention including healthy lifestyles, wider determinants of health and major employers.
10. **Berkshire West** has drawn up a long list of ten potential shared priority areas where significant improvements could be made by working together at Place in a more integrated way:
   - Same day urgent access
   - High cost/high complexity placements
   - Continuing Healthcare (CHC) and Joint Funding arrangements
   - SEND services.
   - Intermediate care services
   - Mental Health (Children and Young People)
   - Reducing preventable premature deaths
   - Reducing infant mortality
   - Workforce enablers
   - Technology enabled care.

All are aligned with the areas of focus for BOB ICP and our local H&WB Strategy. The focus now is on scoping out the specific opportunities within these service areas and then prioritising the list so that two or three high-impact areas are identified.

Enabling and supporting the development of place-based partnerships

11. To support the development of strong Places and based on learning and experiences from other Place-Based Partnerships, we have developed an example maturity matrix and associated success criteria (Appendix One, summarised in Fig 1 below). This may be used by the Place-based Partnerships (if agreed by partners) as a self-assessment tool to help set an initial baseline and to support ongoing continuous improvement as Partnerships.

Figure 1: Place-based Partnership Maturity Matrix



Developing Relationships

12. We have secured support from a System Leadership and ICS Development Programme provided by the Local Government Association, NHS Providers and NHS Confederation. This Programme is providing facilitation to Place Based Partnership development workshops in all three Places.

13. The workshops have and will focus on learning about each other's organisations, establishing common purpose and priorities, and establishing agreed ways of working in partnership at Place to best deliver against these priorities. Each Place Partnership will also engage in ongoing leadership development work subject to further local discussions.

Governance development

14. We need the kind of collaborative arrangements that will enable us to better align, leverage and combine our collective capabilities to achieve shared health and wellbeing goals for residents of Places.

15. PBPs represent the health and care system in Places and members can use the authority delegated to them by their Boards to leverage resources and contribute to the health and wellbeing of people living in respective Places. They will drive joint working and enable provider collaborations (including with primary care, voluntary sector, and independent sector).

16. PBPs provide a mechanism for collaborative action and common decision-making for those issues which we can only tackle together at a local level (county, district, and neighbourhood).

17. National legislation is not prescriptive about what arrangements should be established to support effective working at Place. National policy does incorporate a principle of ensuring decisions are taken as close to communities as possible[2], and locally we are committed to Place being the 'engine room' of delivery against our strategic objectives.

[2] It is important to note local authorities and combined authorities are not defined as relevant bodies in s65Zs and therefore should continue to use existing provisions in s75 of the 2006 Act. LA and CA cannot make arrangements under s65Z5 in respect of their own functions and will need to do these using powers in s75 of the 2006 Act and associated partnership regulations.

18. Section 65Z5 of the 2022 Act provides new powers for statutory NHS bodies (i.e., NHSE (NHS England), ICBs, NHS Trusts and NHS Foundation Trusts) allowing them to delegate their functions to each other, and to local authorities (LAs) and combined authorities (CAs)[3].

19. There are several options that the ICS can consider when looking to strengthening partnership working and developing delegation models including:
    i. Operating partnership collaborations based on executive authority.
    ii. Using existing mechanisms such as Health and Wellbeing Board(s)
    iii. Creating ICB sub-committees at Place level
    iv. Using Section 75 arrangements between ICB / LA / Trust to pool budgets
    v. Creating Provider Collaboratives
    vi. Adopting formal Lead Provider and/or Accountable Care Organisation models at Place and/or spanning Place geographies
    vii. Establishing joint teams

20. In practice we may use a combination of these to best support integration and local priorities. We are recommending that 'form follows function,' with individual programmes of work determining the most appropriate formal delegation arrangements that will results in the best outcomes for our population and the best use of resources. Governance and structures will therefore evolve with the partnerships.

Operating Model and Programmes of work

21. The ICB will initially manage responsibility for the delivery of any agreed Place-based functions through the Place Directors. The Place Director will be accountable to the ICB for the discharge of delegated authority through the Chief Delivery Officer and CEO in line with the formal ICB scheme of delegation.

22. Naturally, Local Authority services work most comfortably at or within Place (rather than at a BOB system level) in accordance with local government accountability structures. However, there is no clear national guidance or standard model for how NHS services should be structured between 'Place' and 'System;' it is therefore for PBPs and the ICB to determine the most appropriate arrangements, and work together to agree an ICB Operating Model that effectively support these. It is acknowledged that this model is not yet fully developed.

23. The ICS brings the benefits of working at scale to deliver corporate functions, tackle major strategic issues and reduce unwarranted variation. Place-based partnerships are better suited to delivering joined-up care to meet the distinctive needs of local populations, communities, and neighbourhoods.

24. Appendix 2 is a working example of how ICB programmes of work may be designated effectively between System and Place.

Role of Provider Collaboratives

25. Provider collaboratives are partnerships that bring together two or more health and/or social care provider organisations to work together for the benefit of entire populations. Provider collaboratives can work at place, ICS or in multiple ICSs.

26. Oxford Health NHS FT (OHFT) has extensive experience leading collaboratives for adult mental health (with voluntary sector partners) and was one of the first wave specialist mental health collaboratives. OHFT and Berkshire Healthcare FT have successfully bid to work as an innovator site for a Mental Health Provider Collaborative. Our acute providers have agreed a memorandum of understanding to form an acute provider collaborative and Oxford University Hospital Trust (OUH) and OHFT are also developing a place-based collaborative.

[3] It is important to note LAs and CAs are not defined as relevant bodies in s65Zs and therefore should continue to use existing provisions in s75 of the 2006 Act. LA and CA cannot make arrangements under s65Z5 in respect of their own functions and will need to do these using powers in s75 of the 2006 Act and associated partnership regulations.

27. Ensuring that we develop the right interface between provider collaboratives and place-based partnerships will be an important aspect of our development to ensure we secure the benefits of formal provider collaboratives whilst supporting integration and service models that respond to local population needs.

Next Steps for Place-based Partnership development in 2023/24

28. Input Place Directors are working with local leaders and through existing structures to support the development of PBPs to reflect local circumstances. Between now and the end of 2023/24 the key deliverables will likely be (including draft timelines):

    a. Establish more formal Place-Based Partnership forums based on executive authority, with agreed membership, Terms of Reference and agreed principles around ways of working **by 1 April 2023**.

    b. Have a set of agreed service integration priorities **by 30 April 2023**.

    c. Agree an initial governance structure that supports delivery of the key Partnership Priorities and clarifies the relationships with existing statutory committees (e.g H&WB) **by 30 April 2023**.

    d. As noted above, the solutions to the Place priority service areas may dictate changes to ongoing delegation and governance arrangements (e.g., Provider Collaboratives, Accountable Care Organisation models, etc) therefore further proposals for formal future delegation arrangements, if appropriate, will likely be **developed during the 2023/24 financial year**; and

    e. It is likely that the Place-based Partnerships will also wish to agree a joint Leadership Development programme to run throughout the 23/24 financial year, including regular self-assessment against the maturity matrix.

Recommendations

29. The board are asked to:

- Endorse the key principles outlined in the executive summary.
- Note the progress made in 2022/23 and emerging 2023/24 priorities in terms of service improvement and delivery.
- Note the potential range of governance arrangements and agree that local variation may be required as partnership arrangements develop and mature.
- Note and comment on the broader enabling work outlined in the paper.

Appendix One: Place-based Partnership Maturity Matrix

Component themes and capability development stages:

Component themes	Emerging	Developing	Maturing	Thriving
Shared Vision and Purpose **There is a shared understanding and articulation of the vision and purpose of our partnership.**	Agreement across main partners to work together. Some evidence in individual organisations and at system level of progress on Place vision and purpose, guided by system-wide vision and purpose.	Defined shared vision and purpose guided by System-wide strategy is agreed and in-place. There are examples of good joint working resulting in demonstrable progress. There is an emerging public narrative around the benefits derived from PBP's. Communications and engagement plan developed for Place agenda.	Agreed objectives based on System-wide vision and purpose aligned to deliverables. There is clarity on what happens in Place compared to System. Consistent progress is being evidenced. There is a shared and consistent narrative for all stakeholders. Robust Communications and Engagement Plan in place and being updated appropriately.	Partners first point of call for support is each other rather than the ICS NHS Body. Representations to the ICS are made together as an PBP rather than as individual organisations. Participation and Involvement in the PBP by all partners is seen as business as usual. Full partnership working with a strong public narrative outlining how integrated care and joint working continues to be developed with and its impact on population outcomes and inequalities**.**
Systems mindset and long-term view **Individuals and organisations recognise we are part of a wider, interconnected system and invest in both short-term projects and in building conditions to deliver long-term change.**	Some progress towards defining Partnership priorities. Some understanding of Place architecture across Oxfordshire and some resource plans in-place to deliver priorities. Initial discussion on options for moving functions with linked resources. Risks to delivery of local priorities are identified.	Defined objectives and priorities on existing known local issues and challenges, System priorities, health needs and national priorities. Partnership has clear plans on the resource requirements to effectively deliver objectives including the contribution required of PBP partners to deliver agreed delegated/transferred functions.	Emerging evidence of delivery on existing priorities alongside new objectives and priorities being formed from the systemwide data. Partners have provided the agreed resources for PBP infrastructure. Place based staff are working more closely in line with agreed principles.	Infrastructure and resources are in place to enable the effective delivery of functions and national/ place priorities based on robust performance data. Commitment from Partners to establish further resources as priorities develop and/or there is a variation to the agreed functions of the PBP. The Partnership has a dedicated number of staff working across organisational boundaries and describe themselves as working for Place.

Component themes	Emerging	Developing	Maturing	Thriving
Shifting power to people/families **The partnership approach is informed by meaningful engagement and insight from people who can shape the support and care they receive.**	An approach to involving people/ families in decision making to reflect the diversity of local communities is being put in place. This includes Boards and programme groups.	There is some people/ family involvement in decision making and there are plans to strengthen this. There is a plan to ensure that people/family's involvement is across all ICS Boards and Programme Groups and reflects the diversity of local communities.	People/ families are routinely involved in decision making on all Boards and Programme Groups and largely reflects the diversity of local communities. Representatives can make some decisions on behalf of place and communicate plans, progress, and decisions back to the place. Independent people/ families challenge is built into place decision-making**.**	There is strong, routine people/families' involvement in decision making whose involvement fully reflects the diversity of local communities. People/families' representation can make decisions on behalf of the place and routinely communicate plans, progress, and decisions back to place. Arrangements take account of partners across different places/ICSs.
Trusted, collaborative relationships. **Partners invest in relationships and building trust as a foundation for the delivery of support, services, and long-term change.**	Initial discussions are being held to facilitate representing each other on behalf of the place. Discussions and protocols mirror our Place behaviours framework.	There is a shared ambition to work towards representing each other on behalf of the place in line with our behaviour's framework. Systems support the building of relationships across all place partners.	There is a shared ambition to represent each other on behalf of the place and plans are in development for the next 18 months. Behaviour's framework can be evidenced as embedded.	There is an agreement in place in relation to representing each other on behalf of place and a clear plan in place for next 18 months.
Coordinated delivery of integrated care and support **Partners collaborate to deliver integrated support to people and families**	Local authority, NHS and VCS leads are identified and integrated into a collaborative working network. Understanding is developed around how local authority locality structures operate.	The LA, NHS and VCS leads are represented at Place MDT (Multi-disciplinary Team) meetings and access associated workstreams. Agenda items and decisions relate to local plans for improving outcomes for population health and are informed by the system and	All stakeholders at Place have a voice in decision making. Achievement of Place deliverables is seen as a barometer of integrated team working across health, social care, mental health, and the voluntary sector.	Fully integrated clinical and non-clinical teams are in place, motivated and able to articulate and act on the Place agenda and demonstrate collaborative working. MDT working is high functioning and supported by technology.

Component themes	Emerging	Developing	Maturing	Thriving
		national strategies, best practice guidance and locally agreed priorities. Systems routinely collecting patient experience and outcome measures. Best practice examples of collaborative working between social care, voluntary organisations and health are identified and shared.	Continued development of partnerships across social care, mental health, the voluntary sector, and secondary care that are enabling on-going MDT development and evidence collaborative working. Systems using patient experience and outcome measures to drive local improvements.	The Place based narrative is well understood and strongly supported by all partners. Opportunities to support and improve outcomes for population health linked to LTP (Long Term Plan) is woven into prevention and reducing health inequalities agendas.
Shared governance and accountability **Collaborative governance leads to effective coordination, partners share accountability for the outcomes in the partnership's strategy and for building the conditions to deliver them.**	Starting to establish informal meetings of key partners to focus on outcomes (both System-wide and defined and Place-specific) reporting and oversight. PBP Governance principles agreed e.g., decision-making, avoiding duplicating, building on what exists, iterative and evolves over time as partnership matures.	All Place leaders including clinical and non- clinical leadership formally committed to working together with some examples of how integration supports Place development through OD (Organisational Development). Appointment of key posts, initial governance structures and working groups to develop the infrastructure of the PBP ICP.	Agreed Place leaders, supported by all partners to lead the delivery and development of the Partnership and all actively participating in OD, leadership, and cultural development. Collaborative, diverse, and inclusive Place leadership and governance, reflecting the local population. PBP Board with clear sub-committee structure and clear process for escalations. Established clinical and non-clinical leadership in place with a shared educational programme to tackle improvement concerns.	Place leadership is demonstrated across a larger cohort of leaders at all levels and parts of the Partnership, working collaboratively to address and resolve Place challenges. Tangible improvement and delivery of the Partnership priorities is demonstrated within the Partnership reflecting the population. Place leadership with matured relationships and governance in place with explicit delegation, open book transparency to ensure resources can move in line with agreed clinical pathway changes and risk sharing where appropriate.

Component themes	Emerging	Developing	Maturing	Thriving
Aligning and coordinating use of resources **Funding and resources required to deliver our vision are aligned or shared across the partnership to enable more integrated people-focussed support.**	Informal discussions taking place between PBP Partners regarding planning for financial flexibilities to enable the achievement of Place level priorities. Informal discussions between PBP and ICS NHS Body on potential future framework.	PBP Partners establish formal group to take forward discussions relating to strategic allocation of financial resources, commissioning and contracting. PBP representatives participate in System wide sub-groups on future Financial Framework.	PBP agrees and commences initial contract model with associated agreements and governance between PBP partners, as to how finance flows between organisations to support the delivery of priorities and functions.	PBP proactively tackling financial challenges as a collective. The associated agreements and governance between PBP partners as to how finance flows between organisations are in place and operational. Overall system contract place strategy agreed with outcomes reflective of current and future population need and local priorities. Significant levels of the System's financial resources are delegated to PBP accountability framework based on health outcome focused performance targets.
Systems leadership **The behaviours of people in authority support leadership as a collective activity, which mobilises others to deliver our vision, rather than relying on roles or formal authority**.	The newly forming Place Based Partnership includes all partners to consider collaborative ways to share information/build understanding to ensure that work around the Place agenda is considered across integrated multi-disciplinary teams as they form and develop. The need for consistent leadership behaviours is recognised and the behaviours framework understood.	Place based priorities and objectives are known and understood and are being actively considered in plans around asset-based community development and social prescribing and population health management. Multi-agency integrated strategies are being developed to engage, involve and pro-actively provide support across place-based partners.	Place level champions for Place based Partnerships are empowered at both a strategic and operational level in support of collaboration across all partners. Partners proactively articulate and share learning and best practice around PBP Programme workstreams and are used as an exemplar to establish integrated multi-disciplinary teams and ways of working.	There is defined/dedicated clinical and management capacity/ representation and infrastructure to support both local and system-wide ambitions around LTP objectives for Place based Partnerships and Integration White Paper involving health, social care, and voluntary sector.

Component themes	Emerging	Developing	Maturing	Thriving
Culture of evaluation and learning that enables adaptation. **Partners reflect on progress and use what we are learning to influence decision-making, we adapt our approach based on what we learn**.	Plan in development to support closer working together between PBP partners and the transition to new operating models. Importance of training needs analysis and shared learning as part of agreed set of values and behaviours is acknowledged and baselined. Stakeholder mapping started, including universities, AHSN (Academic Health Science Network) focusing on developing our culture of improvement. Baseline to include knowledge at a GP Practice/ PCN (Primary Care Networks) level, Social Prescribing Link Workers, Practice Participation Groups and Healthwatch.	Existing materials utilised where applicable and involvement in development of new support materials/ methods of engagement. Examples of best practice identified and shared. Training needs at Place included into wider training plans. Opportunities to use and share training resources with other systems. Discussions around how to restore and refresh knowledge element of staff training across relevant teams including, primary care, community and mental health, local authority/ social care teams. Stakeholder mapping in place.	Clear evidence that the outcomes from PBP plan has tangibly enabled the development of skills and capability. PBP values and behaviours embedded through learning interventions within all PBP partners and reflected in the decision making of the PBP board. Evidence of learning opportunities being taken to use existing training within existing structures as well as develop and adapt materials locally that can be used elsewhere. Learning Networks established including communication needs and preferred engagement methods.	A learning environment has been created between PBP partners and local communities to reduce health inequalities and maximise population health outcomes. All PBP partners agree to developing a common core skills and characteristics learning programme across PBP that addresses the need of all members. Learning and Development Communications and engagement plan implemented across all relevant groups and all other key stakeholders. Clear structure is in place to identify and support newly recruited staff in key roles around the Place agenda to be brought up-to-speed, so momentum is not lost.

Shared data and information **Insights from population level data, individual level data and information about experiences are collected, shared, and used effectively across our partnership.**	Initiation of a Place review specifically around what qualitative and quantitative data is required from all partners to improve population health linked to LTP deliverables. Members of Public Health England are identified focusing on proactive use of preventative health and timely referral to local support services. Leads for Digital Transformation and Quality markers identified and involved in forward plans. Specific work is being undertaken around vulnerable communities.	Place has enough data and intelligence to be able to recognise variation and gaps over time, alongside other patient, and carer experience data. There is a focus alongside public health data experts on improving data and intelligence where gaps have been found and working with Digital Transformation Leads to reduce/ resolve these issues. Understanding is being developed around predicted population changes and evidence of addressing specific needs of vulnerable communities. Mapping of available services to share best practice and identify outliers.	Place based data and intelligence is visible, respected, being assessed, shared, and used alongside other quality data for comparative purposes and to drive system policies/programmes. Specific support needs are being advanced as part of population health management approaches of priority workstreams. Public Health and Digital Transformation teams actively consider opportunities to incorporate/ reduce barriers to accessing system data. New forms of data and intelligence are continuously being sought and introduced to fine tune approaches and maximise impact.	Access and use of data and information to support Population Health Management and drive system improvement. Demonstrably improved outcomes are being achieved for the PBP population, including reducing the gap between the best and worst life expectancy. A ‘prevention first’ ethos has been successfully embedded. Variation in the identification, recognition, and support of delivery of Place based priorities is given focus to systematically identify outliers and measure quality improvement. The specific needs of Place are incorporated into population health management solutions on priority workstreams.

Appendix Two: Effective System and Place working.

Aspects to be considered by ICS partners include:

- Is the service predominantly focused within the Place geography? E.g., patients generally cannot travel a significant distance to access the service.
- Does the service require integration with individual Local Authority services, including opportunities to pool budgets and jointly commission services?
- Does the service need substantial tailoring to meet local needs?
- Does the service integrate with local community services and/or community assets?
- Is the service highly specialised?
- Could the service be delivered under a 'Centre of Excellence' model across BOB? E.g., one acute being the CoE for robotic surgery.
- Would consistency of approach to planning/contracting/delivery of the service across a broader footprint benefit our patients?
- Are there efficiency opportunities through economies of scale?
- Is there a relationship with the NHSE Regional Team that would be better managed centrally?
- For Berkshire West: Would the service benefit from being delegated within Place to individual Local Authority level?

The table below demonstrates a potential service designation based on the application of the above criteria:

Service Area	Example BOB-Wide Remit	Example Place Remit[4]
Urgent and Emergency Care	ICB will have responsibility for the following aspects of UEC: • EPRR system management incl. System Control Centre • NHSE / regional assurance relationship • SCAS contract • Lead work on integrated contracting for 111, UTC, OOH and CAS (Clinical Advisory Service) • Transformation support through UEC Programme	Responsibility delegated to Place. Majority of UEC work will be to align budgets, oversee the Better Care fund and integrate care for people with urgent care needs. Prioritisation of ringfenced investment in UEC pathway
Community Services	ICB will have responsibility for the following aspects of community services: • Core community services contract management • Assurance of key priorities identified through region	Responsibility delegated to Place to integrate community services with other services provided by statutory and non-statutory organisations.

[4] Note that Places will need to actively consider how these remits and duties are discharged within Place governance structures, including elements 'owned' at a Local Authority level (particularly pertinent for the Berkshire West Place)

Primary Medical Services	Most responsibility is at ICB with opportunities to share learning and reduce unwarranted variation. • Primary Care model transformation • Contracting, quality oversight, etc. • Estates expertise to link with Planning Departments at LAs to ensure appropriate funding secured from new housing developments. • ARRS (Additional Roles Reimbursement Scheme) compliance and funding allocation	Place will be responsible for the involvement of local primary care (practices, PCNs, federations) and the integration of primary care with other providers. • Implementation of transformational models and integration with UCR (Urgent Community Response), OOH, GP visiting to support people at home and avoid unnecessary admissions to hospitals. • Escalation for local issues and access inequalities
Adult mental health, Learning Disabilities, Autism	Significant BOB-wide remit including: • Potential for provider collaborative between Trusts to drive at scale transformation. • Specialist commissioning over multiple ICSs (secure MH (Mental Health) and Eating disorders) • Assurance/ oversight on LTP commitments/ MHIS compliance • Driving BOB-wide transformation work • Development of a population health management approach for use of overall Mental Health resources against need and to tackle inequalities Opportunities for provider collaborative between OHFT and BHFT (Berkshire Healthcare Foundation Trust) to capitalise of benefits of scale and to reduce unwarranted variation	Significant responsibility at Place to align budgets with Local Authorities and integrate with social care, local authorities e.g., districts/city councils, primary care, VCS: • Implementation driven at Place due to interdependencies with UEC pathways, Primary Care, LA, and voluntary services. • Transformation & recovery of material local service issues Opportunities for provider collaborative between OHFT and BHFT to be vehicle for alignment and integration of budget between NHS, Local Authority etc.
Child & Adolescent Mental Health	Significant BOB-wide remit including: • Potential for provider collaborative between Trusts to drive at scale transformation • Specialist commissioning over multiple ICSs (secure MH, CAMHS (Child and Adolescent Mental Health Services) T4 and Eating disorders) • Assurance/ oversight on LTP commitments/ MHIS compliance	Significant responsibility at Place to align budgets with Local Authorities and integrate with social care, local authorities e.g., districts/city councils, primary care, VCS: • Implementation driven at Place due to interdependencies with UEC pathways, Primary Care, LA, and voluntary services. • Transformation & recovery of material local service issues

	• Driving BOB-wide transformation work • Development of a population health management approach for use of overall Mental Health resources against need and to tackle inequalities Opportunities for provider collaborative between OHFT and BHFT to capitalise of benefits of scale and to reduce unwarranted variation.	Opportunities for provider collaborative between OHFT and BHFT to be vehicle for alignment and integration of budget between NHS, Local Authority etc.
Children's Learning Disabilities (LD), Autism & Special Educational Needs (SEN)	Most responsibility for children's LD, Autism and SEN services delegated to Place except: • SME (subject matter experts) support to resolve Place escalation • Contracting oversight	Majority of responsibility for children's LD, Autism, and SEND work will be delegated at Place.
Continuing Healthcare (CHC) and Joint Funding	Responsibility for standardisation of assessment and review processes to reduce unwarranted variation in practice. Significant BOB-wide remit including: • Potential for BOB-wide CHC assessment service, to drive consistency and equality of assessment outcome • BOB-wide transformation work	Responsibility for brokerage and managing the market to ensure equitable access to best value care packages: • Commissioning of care done at Place noting Joint Commissioning opportunities with LAs • Joint Funding pathways agreed at Place based on local needs
Maternity	• BOB-wide transformation work • Ability to "do it once" when designing best practice pathways and reduce unwarranted variation	Not delegated to Place but need to be informed and understand performance and impacts on local populations
Planned Care (all ages)	Potential for Provider Collaborative to capitalise on the benefits of working at scale, improve access and reduce unwarranted variations. • Ability to coordinate and potentially realign service provision more efficiently across the three Places based on ICS-wide intelligence and direction • BOB-wide transformation work	Not delegated to Place but need to be informed and understand performance and impacts on local populations. May need to some elements to be delegated to place in the future (e.g., pre-operative or post-operative care)

Cancer	Responsibility is at ICB with opportunities to share learning and reduce unwarranted variation. • BOB-wide transformation work • Ability to coordinate and potentially realign service provision more efficiently across the three Places based on ICS-wide intelligence and direction • Alignment with Thames Valley Cancer Network	Not delegated to Place but need to be informed and understand performance and impacts on local populations. May be opportunities to incorporate and integrate other services (e.g., VCS) in the future.
Clinical Programmes (LTCs)	Responsibility is at ICB with opportunities to share learning and reduce unwarranted variation. • BOB-wide transformation work • Ability to "do it once" when designing best practice pathways for management of identified cohort long term conditions.	Not delegated to Place but some elements of LTCs could subsequently be delegated to Place and links with health inequalities and prevention work.
Pharmacy, Optometry and Dental (POD)	Responsibility is at ICB with opportunities to share learning and reduce unwarranted variation. • BOB-wide transformation work • Consistent contracting and quality oversight function • Medicines optimisation at scale	Not delegated to Place but need to be informed and understand performance and impacts on local populations.
<u>Enablers</u>		
Quality Assurance and Safeguarding	• BOB-wide oversight to support the Quality and Safeguarding leads already embedded in organisations at Place	• Place-based leads within BOB team
Inequalities and Prevention	• A BOB-wide 'push' data model – central source of intelligence to prompt Places by identifying intervention opportunities on inequalities and prevention. • Will need to link with data leads in all Place organisations	• Place responsible for implementing improvements to address. • Place responsible for funding decisions
Finance and contracting	• BOB-wide oversight of financial position and setting of broad planning parameters • BOB-wide contract management	• Place-based leads within BOB team

Estates and capital planning	• Funding allocation process managed centrally • BOB-wide oversight of major estates developments	• Place focus on better utilisation of local public assets within Place Based Partnership control
Planning and performance management	• Performance and Assurance management and oversight • Process managed centrally • Can we get consistent support to service data asks of Place committees	• Process managed centrally but Place-Based Partnership input and approval of plans required (where delegated) and preferred (where not delegated)
Digital and IT (Information Technology)	• Central corporate function	• Place commissions specific support where needed
Research and Innovation	• BOB-wide network	• Work with R&D leads within organisations at Place