NHS

Agenda Item 12

Meeting: Buckinghamshire, Oxfordshire, and Berkshire West CCGs Governing Bodies Meetings in common (in public)

Date of Meeting	9 September 2021
Title of Paper	ICS Development
Lead Director	Matthew Tait, Deputy ICS Lead
Author(s)	Matthew Tait, Deputy ICS Lead; Jo Cogswell, Director of Transformation and Catherine Mountford, Director of Governance
Paper Type	Information and Assurance
Action Required	The Governing Body members are asked to • Note the arrangements put in place to manage the overall development and transition programme and progress made to date • Confirm that the arrangements give assurance (through membership of the Development Board, Audit Committee links and proposed GB reporting) that the management of safe transfer of CCG staff and functions is covered in the programme

Executive Summary

The paper outlines the BOB Integrated ICS approach to the development and transition of the BOB Integrated care System to form an Integrated Care Board from the1st April 2022 subject to the necessary legislation.

The paper update on the overall programme structure and outlines key issues and progress with regard to governance considerations, place based decision making and readiness to operate requirements.

ICS DEVELOPMENT

1. Introduction

Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area.

They exist to achieve four aims:

- **improve outcomes** in population health and healthcare
- **tackle inequalities** in outcomes, experience and access
- enhance **productivity and value for money**
- help the NHS support broader **social and economic development**

Following several years of locally led development, and based on the recommendations of NHS England and NHS Improvement; the government has set out plans to put ICSs on a statutory footing. Collaborating as ICSs will help health and care organisations tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible

This report outlines the progress and process for the BOB ICS to move the ICS onto a statutory footing in line with the expected legislation.

2. Management of Transition – the Programme structure

As reported to the June meeting an ICS Development Programme has been established under the leadership of the Deputy ICS Lead. The structure of the programme is shown in appendix 1.

The ICS Development Board is chaired by the ICS Chair. Membership comprises; ICS Lead, Dep ICS Lead, workstream Senior Responsible Officers, Clinical Chairs and place based representation. The membership is being expanded to include the LMC and CCG non-executive representation. The purpose of the Board is to provide oversight and guidance to the ICS Development Programme, resolving issues escalated to it and making recommendations to System Leadership Group and CCG governance as appropriate. This link back through to the CCG governance structure and should remove the need for further meetings of the Architecture and Oversight group.

The ICS Development Transition Group (TG) meets weekly and is chaired by Deputy ICS Lead. Membership comprises; Workstream SROs and ICS programme team. Its purpose includes; reviewing and assuring workstreams plans, providing advice and guidance to workstream SROs as necessary, identifying and if possible, facilitating resolution of any cross workstream issues, dependencies or risks which may impact on delivery of agreed actions/milestones and the escalation of issues for resolution to ICS Development Board in a timely manner.

NHS

After an initial informal set up meeting the board has meet twice reviewing workstreams updates, keys risks and having broader discussion around the service development plan, governance issues and place-based decision making.

3. Progress to date

An initial system development plan was submitted at the end of June which outlined the present position against all key lines of enquiry and outlined asset of actions and milestones for establishing the ICS board and further developing the BOB Integrated care system. This plan has been reviewed by NHSE/I and a formal feedback letter has been received. The full SDP is available to Governing Body members on request and an updated plan will need to be submitted at the end of October.

3.1 Recruitment

The recruitment process for the Integrated Care Board Chair designate is underway and an appointment is expected in September. The recruitment for the Chief Executive Officer designate commenced on the 1st September and should be appointed by November. The broader executive team will need to be in place before March 2022.

3.2 Guidance and Governance

Considerable guidance is now in development and being issued with the latest batch published on 19th August 2022 covering:

a) Interim guidance on the functions and governance of the integrated care board
   i. Draft model constitution
   ii. List of statutory CCG functions to be conferred on ICBs
b) HR Framework for developing Integrated Care Boards
c) Building strong integrated care systems everywhere: guidance on the ICS people function
d) ICS implementation guidance: ICB readiness to operate statement (ROS) and checklist
e) ICS Implementation Guidance: Due Diligence, Transfer of People and Property from CCGs to ICBs and CCG Close Down

This guidance does confirm some terminology changes which are useful to highlight:

- The statutory organisation will be the **Integrated Care Board (ICB)** this was previously referred to as the ICS body
- The **Integrated Care Partnership (ICP)** which is the partnership committee and was previously referred to as the Health and Care Partnership
- **Place based partnerships** which have locally been referred to as integrated care partnership
- **Provider Colloboratives** which are partnership arrangements involving at least two trusts working at scale across multiple places

The ICB is required to have a constitution that details its governance and operating model. The Bill sets out that CCGs will propose the constitution for the first ICBs to NHSEI, which will require confirmation that designate board members are supportive of its terms. NHSEI has developed a draft model constitution which should be used to guide the development of and consultation on the local version. The Good Governance Institute (GGI) has been commissioned to undertake work to support development of the ICS governance structures.

This will build on good practice, guidance, and local issues. GGI are due to report by the end of September, and this will provide a proposal for further engagement with partners.

*The **statutory elements** of the governance structure are (see guidance for description of roles/functions):*

- Integrated Care Partnership (ICP) – a committee
- Integrated Care Board (ICB) – a statutory organisation with a unitary Board
  - Audit and Remuneration Committees

Areas for Local agreement

- Committees of the ICB that will give assurance on delivery e.g. Finance , Performance and Quality
- Place Based Partnerships: We have agreed a principle of subsidiarity and the three places (Buckinghamshire, Oxfordshire and Berkshire West) within the ICS will be part of the governance arrangements.
- BOB Programme/Transformation Boards.
- Committees/arrangements for undertaking any direct commissioning delegated by NHSEI and for joint arrangements for specialised commissioning

The operating model and all arrangements for governance of the ICB must be included in the Constitution (NHSE has developed a draft model that will be used to guide the local version). The Bill going through parliament indicates that CCGs that will propose the constitution for the first ICBs. A final version of the ICB Constitution must be approved before the end of Q4 2022 by NHSEI.

Focus for further work

It is relatively easy to outline the key elements of a governance structure but there are areas of detail that need further work and wider engagement before proposals are finalised, these include:

- **Confirming membership of ICB Board**;
  - The minimum requirements of the guidance have an ICB Board membership of ten (Chair, Chief Executive, two non-executives, Director of Finance, Medical Director, Director of Nursing, three partner members);
  - The ICB Board contains three categories of partner members (one from each of NHS Trusts/Foundation Trusts, primary medical services providers and local authorities). The guidance indicates appointment combines a nomination and assessment process. It is expected that details regarding the organisations which can take part in any nomination processes will be set out in regulations later this year.
- **Establishment and membership of ICP** including selection of Chair; this needs to be undertaken jointly with the relevant local authorities (the five with social care responsibilities). Statutory guidance will be developed by the DHSC working with NHSEI and the Local Government Association. This will need to include agreement on, given an agreed function, whether the members are Councillors/NEDS or officers/executives. The working assumption is that the ICP will have a wide and inclusive membership.

- **Level of delegation to place** and how this is represented in the governance arrangements (Place Boards, role of HWB Boards, joint commissioning etc, link to Place delegation work). All functions are retained by the ICB until the delegation is agreed and incorporated into the operating model and governance structure
- **Level of readiness for delegation of commissioning from NHSE**. For 1 April 2022 at minimum this is:
  - assuming delegated responsibility for Primary Medical Services (as currently undertaken by all CCGs). Depending on the arrangements for the delegation this may require a Committees of the ICB to be established (as CCGs have had to have Primary Care Commissioning Committees)
  - Establishing mechanisms to strengthen joint working between NHSEI and the ICB, including through joint committees, across all areas of direct commissioning?
- **Clinical leadership/engagement**: This covers a broad range of areas such as clinical involvement in governance, transformational change, assurance, representation and professional development. All these aspects will need to be embedded in our processes and the way we do things.
- **Patient/public/Healthwatch/voluntary sector involvement** will need to be embedded in everything we do ("the way we work"). This is built up from the most appropriate geography (e.g. PPGs and Practices/PCNs; place) or the lead organisation and most of this will be delivered in place. How this feeds into the governance structures will need to be clear and this is part of the work being taken forward through the Communications and Engagement workstream.

At the ICS Development Board it was agreed that we would set up some meetings with specific groups to work through some of these questions. This would include Chairs/Chief Executives of NHS Trusts; Primary Care through the work being led by LMC/CCG Chairs; possibly Place "boards" and we would ask Local Authorities what the appropriate route would be to engage more widely. The output of the engagement would be shared with the ICS Senior Leaders Group and CCG Governing Bodies in October for further discussion and development.

3.3 Clinical Leadership – primary care

Ensuring and enabling effect representation, involvement and influence from primary care is key to the future of the ICS. General Practice is at the heart of many aspects of the Long Term Plan.

The CCG Clinical Chairs are working with the LMC across BOB to develop a set of ideas and proposals for how primary care might be reflected in the ICS, that is the ICB, the ICP and the Place Based Partnerships. Guidance documents specifically highlight the involvement general practice and primary care networks.

The Buckinghamshire, Berkshire West and Oxfordshire LMC undertook a survey of all GPs to draw out views and ideas for the future. This survey is a part of an overall approach that will see a set of proposals collated in September for wider discussion and engagement through October. Consideration has been given to

- General Practice as key providers of services
- Primary Care Networks – described as the building blocks of integration
- GP Federations as providers of services at scale
- Local Medical Committee
- Wider general practice staff
- CCG Clinical Leads

Initial engagement has been undertake with a strong emphasis on clinician to clinician discussions. There was early recognition of the experience and skills held by the CCG GPs and specific sessions took place for this group.

3.4 Place based design and decision making

The ICS will only succeed if we develop both a strong system and strong places and the BOB ICB will need to outline how places are central to the operating model to support integration and improved outcomes. Good progress has been made on different elements of place working and integration over the last few years and any models developed by the ICB will need to recognise and reflect these.

Capacity and capability to support place working through CCG staff will largely be retained through the employment guarantee but the mechanisms and governance to empower place and support integration will need to be developed for the new organisation.

Initial scoping work has proposed to use programme areas such as Urgent and Emergency Care and Care for families and babies to help co-design place decision making models moving forward. This will also include discussions on how to retain and build on progress in key areas already embedded in co-commissioning arrangements.

Governance and delivery models to empower place to focus on improving outcome and progressing integration range across:

- Joint Working Groups
- Decision making by individuals and teams
- Committees in Common
- Lead Providers
- Joint Leadership team / Joint Ventures

During quarter 3 of 2021/22 further work will be undertaken with place based leaders to identify preferred options and to access current capability and capacity with a view to having preferred models developed by the 31st December 2020.

3.5 Working with South Central West Commissioning Support Unit

We have undertaken a review of services we commission from SCWCSU to inform the development of the ICB. Given timelines it is unlikely that any substantial changes to the range of services commissioned will be made prior to the 1st April 2022 and we would seek to reshape delivery functions through 2022/23.This is a region wide approach and we are working through any necessary exceptions to this with NHSEI colleagues. The focus of the transition will therefore be to work with SCW on ensuring CSU staff are embedded in the ICB functions to

create a consistent approach from the 1st April. This will need to be reflected in revised service level agreement.

4. Next steps on safe transition and readiness to operate

The guidance published on 19 August was supplemented by detailed information relating to the Readiness to Operate Statement and Due Diligence Checklist. These set out key deliverables and activities that need to be achieved in order that the ICB can be fully functioning on 1 April 2022.

The Safe Transition workstream will use these deliverables and activities to develop a critical path, highlighting dependencies and setting out the order and timeframe in which the delivery must take place. The programme structure will support and monitor delivery and SROs will report regularly on progress.

NHSEI will regularly monitor progress against the Readiness to Operate Statements. Progress will be managed through the ICS Development Board and reported to Governing Bodies.

With greater clarity on the expected timeframes for delivery of key aspects of work a plan on a page is in development – this will be used to illustrate the overall approach and to provide context to the more detailed deliverables. This will be shared with Governing Bodies.

NHS

Appendix 1 Programme Structure