Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group Board Meeting

Date of Meeting: 28 November 2019	**Paper No: 19/67a/b/c**

Title of Paper: Development of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Paper is for: (please delete tick as appropriate)	**Discussion**	✓	**Decision**	✓	**Information**	

Conflicts of Interest (please delete tick as appropriate)	
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	
Conflicted party is excluded from discussion	

Purpose and Executive Summary:

Development of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) has been an evolving process and discussions have been held at Board workshops. The ICS is not an organisation and works as a partnership. Currently there are no formally delegated responsibilities from the CCG to the ICS and individuals working together act on the basis of their individual authority.

Over the last few months progress has been made in developing more formal arrangements and these are presented to the Board today.

This paper contains the following parts:

Paper 19/67a
This confirms the status of BOB as an ICS and specifies the financial agreement between the system and the national and regional teams. In order to support the further development of the ICS in 2019/20, the document sets out some of the expectations of ICSs and the responsibilities and flexibilities the system will receive in return.

Paper 19/67b
Through our joint working as part of the BOB ICS the three CCGs have committed

to, where appropriate, undertaking some Commissioning decisions at scale. This needs to be supported by appropriate governance arrangements. 2.1. This proposes the development of a joint committee to enable joint decision making where we are commissioning at scale across the 3 CCGs.

Paper 19/67c
There would also be benefit to the three CCGs working together more closely and with NHS England in the commissioning of Primary Care and Specialised Services and this paper includes draft Terms of Reference for two Boards. The Primary Care Board will not replace the local Primary Care Commissioning Committees within each CCG, which will continue to support local decision making mainly associated with place based GP practices.

Engagement: clinical, stakeholder and public/patient:
Not Applicable.

Financial Implications of Paper:
This will be reflected in the development of the financial framework for the ICS which will be reviewed by the Finance Committee.

Action Required:
The Board is asked:
Paper 19/67a

- To approve the Memorandum of Understanding for BOB ICS

Paper 19/67b

- To agree to the establishment of a joint committee with Buckinghamshire and Berkshire West CCGs to enable us to take certain decisions jointly under section 14Z3 (2)(b) of the National Health Service Act 2006
- Should agreement be provided by all three CCGs during November 2019 then the CCGs agree to hold the first meeting of this Joint Committee in January 2020, following the adoption of the changes required to CCG Constitutions

Paper 19/67c

- Discuss and feedback on Terms of Reference as attached for
  - BOB ICS Primary Care Board
  - BOB ICS Specialised Commissioning Planning Board

OCCG Priorities Supported (please delete tick as appropriate)	
✓	Operational Delivery
✓	Transforming Health and Care

✓	Devolution and Integration
✓	Empowering Patients
✓	Engaging Communities
✓	System Leadership

Equality Analysis Outcome:
Not applicable

Link to Risk:

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Clinical / Executive Lead: Dr Kiren Collison Clinical Chair; Louise Patten, Chief Executive

Date of Paper: 20 November 2019

Paper 19/67a ICS Memorandum of Understanding

Purpose/summary

As part of becoming an ICS, BOB is required to sign a memorandum of understanding (MoU) with NHS England and NHS Improvement. The MoU sets out an agreement between the ICS and the national bodies on the following areas:

1. Objectives – reflecting the objectives of the national ICS policy
2. National and local priorities – including those local priorities which will be set out in our Long term plan and the move towards one CCG/AO
3. Regional and national support – remains high level while we confirm our priorities
4. ICS financial framework – describing the agreement in place for 19/20, confirming transformation funds and confirming the steps which BOB has committed to take
5. System responsibilities and flexibilities – setting out how the national policy will be applied in BOB, in particular in relation to oversight

The MoU will be signed by Fiona Wise, BOB ICS Executive Lead, for the ICS and by Anne Eden, Regional Director, for NHS England and NHS Improvement. The ICS System Leaders Group (SLG) have agreed that the statutory boards of BOB's NHS organisations should approve the MoU prior to signing.

Requirements of the MoU

The most significant requirements placed on the ICS as part of this MoU relate to the development of a financial framework. Unlike other ICSs, BOB has not been issued with a system control total in 2019/20 in in recognition that BOB ICS is making the transition from a place-based ICS working to wider system working across the BOB footprint.

Receipt of 2019/20 transformation funding is instead linked to delivery of the following four conditions:

i. Establish a system level Financial Oversight Group which will provide collective finance leadership across the STP/ICS.
ii. Formalise system wide financial reporting arrangements to support management and delivery of the 2019/20 financial plan.
iii. Design a financial framework for the ICS, formalising how system partners will work together within any nationally mandated financial framework for ICSs. The framework will be developed in year with a view to implementation from April 2020.
iv. Develop and implement appropriate risk management arrangements which support and incentivise system delivery.

In previous years MoUs agreed by ICSs, including Buckinghamshire and Berkshire West, have included detail on local priorities and associated national or regional support. Given the ongoing work on the ICS Long term plan, this MoU references the local priorities which are set out in that Long Term Plan.

The MoU also incorporates other items which have been agreed with NHS England and NHS Improvement separately, including the Long Term Plan expectation that

ICSs will typically have one CCG. In BOB, a case for change will be developed following a period of engagement from October to December 2019. Subject to the outcome of consultation, the intention for BOB is that the ICS will have one CCG by April 2021 and one Accountable Officer and single management team from April 2020.

The MoU reflects those separate discussions and does not place further requirements on the ICS.

The attached MoU was reviewed by the Audit Committee on 17 October 2019 and they agreed to recommend it for approval by the Board.

Memorandum of Understanding for Integrated Care Systems

Dear Fiona,
We are writing to confirm the status of Buckinghamshire, Oxfordshire and Berkshire West (BOB) as an Integrated Care System (ICS) and to specify the financial agreement between the system and the national and regional teams.
In order to support the further development of the ICS in 2019/20, this document sets out some of the expectations of ICSs and the responsibilities and flexibilities the system will receive in return.

1. Objectives

An ICS brings together local organisations to redesign care and improve population health, creating shared leadership and action. They are a pragmatic and practical way of delivering the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care, consistent with population needs and ambitions set out in the Long Term Plan. They are expected to make faster progress than other health systems in transforming the way care is delivered, to the benefit of the population they serve. ICSs will:

- re-design and integrate clinical and care pathways to better meet the needs of the local population, incorporating use of prevention and self-care where appropriate;
- develop population health management approaches that facilitate the integration of care
- begin to deliver the service changes set out in the Long Term Plan, in particular to:
    - Boost out-of-hospital care, and finally dissolve the historic divide between primary and community services;
    - Re-design and reduce pressure on emergency hospital services;
    - Give people more control over their own health, and more personalised care when they need it;
    - Implement digitally-enabled primary and outpatient care; and
    - Increasingly focus on population health and local partnerships with local authority-funded services
- accelerate primary care networks (PCNs) as the foundation of their ICS and to deliver national service specifications and design care models to meet population need;
- work with key system partners and stakeholders including patients and residents and their democratic representatives, health and care staff, local government and the voluntary sector;
- take collective responsibility for managing financial and operational performance, quality of care (including patient/user experience) and health and care outcomes;

- implement new methods of payment that support integration of services and population health management approaches, whilst enabling delivery of a shared system control total;
- create more robust cross-organisational arrangements to tackle the systemic challenges that the health and care system is facing;
- act as a leadership cohort, demonstrating what can be achieved with strong local leadership, operating with increased responsibilities and flexibilities; and
- commit to developing and disseminating learning, together with the national bodies, so that other systems can develop as ICSs.
- Make progress against the ICS maturity matrix

2. National NHS and local priorities

The NHS guidance for refreshing 2019/20 plans confirmed the priorities set out in the Long Term Plan. We are expecting ICSs to go further than other systems in delivering these and driving improvement. ICSs are also expected to implement their local priorities as outlined in the their response to the Long Term Plan submitted in November. BOB is currently developing its response to the Long Term Plan and we expect the ICS to use this as a key opportunity to set out its local priorities and engage with its partners and communities on them.

The Long Term Plan also sets an expectation that ICSs will typically have one CCG. In BOB, a case for change will be developed following a period of engagement from October to December 2019. Subject to the outcome of consultation, the intention for BOB is that the ICS will have one CCG by April 2021 and one Accountable Officer and single management team from April 2020.

3. Regional and national support

Regional and national teams will work with systems to align support to priority areas identified in the ICS's response to the Long Term Plan.
ICSs have been given transformation funding delegated to a host CCG on behalf of an ICS – in this case Oxfordshire CCG – to support the implementation of integrated care. This transformation funding package is set out in Appendix 1.

As BOB develops its financial framework, as set out in section 4 below, the regional team will also provide expertise and support in the development of system finance and risk management.

4. ICS financial framework for 2019/20

ICSs are required to work within a system control total, the aggregate required income and expenditure position for trusts and CCGs within the system, as communicated by

NHS England and NHS Improvement to all system leaders in the financial framework letter from Julian Kelly on the 4th April 2019.
The tables in Appendix 2 set out the organisation control totals together with the Provider Sustainability Funding (PSF) allocations for your system. It also includes a notional system control total recognising that BOB ICS is still making the transition from previous placed based ICS arrangements and is not yet operating under a system control total regime.

We are allocating wave 1 and wave 2 ICSs the same indicative allocation of 'flexible' transformation funding in 2019/20 as they received in 2018/19. Your allocation of flexible transformation funding for 2019/20 is **£3.834m**.
This 'flexible' transformation funding is usually only available to ICSs who are opting into the shared control total and system PSF scheme. However, in recognition that BOB ICS is making the transition from a place-based ICS working to wider system working across the BOB footprint, then transformation funding will be linked to successful delivery of the following four conditions.

i. Establish a system level Financial Oversight Group which will provide collective finance leadership across the STP/ICS.
ii. Formalise system wide financial reporting arrangements to support management and delivery of the 2019/20 financial plan.
iii. Design a financial framework for the ICS, formalising how system partners will work together within any nationally mandated financial framework for ICSs. The framework will be developed in year with a view to implementation from April 2020.
iv. Develop and implement appropriate risk management arrangements which support and incentivise system delivery.

Financial governance arrangements

Definitive allocations are subject to NHS England and NHS Improvement approval. Prior to the release of any of the additional devolved funding included in this package each ICS will need to demonstrate:

- Governance and accountability arrangements so it is clear how decisions are made and who is accountable for delivering value for money from the expenditure.
- Consideration of a value-based allocation process for determining the use of the funding.
- Arrangements for oversight and reporting of expenditure and tracking of benefits realisation.

5. System responsibilities and flexibilities

Where ICSs agree to sign up to the agreed financial framework and demonstrate the capabilities of a mature ICS, we will operate an oversight model that empowers your system to take a shared or leading role in decisions about oversight of trusts and CCGs, supported as necessary by NHS England and NHS Improvement Regional teams, and

with a commitment to minimising the administrative burden placed upon systems. Appendix 3 sets out the national framework for agreement between systems and regional teams.
The agreement for BOB ICS is as follows:

Oversight

- The NHS England and NHS Improvement South East regional team and BOB ICS will operate a place-based approach to system oversight, with provider and commissioner performance (including Primary Care Networks) being overseen together as part of three Integrated Care Partnerships (ICPs).
- The purpose of oversight arrangements is to support the ICS and its constituent parts to deliver improved health and well-being for its communities. Improvement support will be provided by NHS England and NHS Improvement in consultation with the ICS, to complement locally sourced good practice.
- A quarterly oversight meeting will take place for each ICP. This will be attended by the ICS lead, key leaders from ICPs and by NHS England and NHS Improvement and will be the cornerstone of place-based oversight.
    - Quarterly oversight meetings are expected to develop along the lines of the Buckinghamshire pilot.
    - Significant issues and/or deteriorations in individual parts of the system may be addressed through separate mechanisms or meetings. These, and any other oversight activities which happen outside the quarterly oversight meetings, will be agreed between NHS England and NHS Improvement and the ICS at the quarterly oversight meeting.
    - Performance reporting to support oversight discussions can be supported by NHS England and NHS Improvement, by agreement with the ICS.
- This place-based oversight will be complemented by a 6-monthly meeting between the ICS Lead, the Regional Director and the Regional Director of Strategy and Transformation. ICS objectives will also be reviewed and agreed at this meeting.
- Any interventions from NHS England and NHS Improvement will be with the consent of the ICS. The regional team will make reasonable adjustments to allow for this within NHS England and NHS Improvement's governance arrangements.
- NHS England and NHS Improvement will minimise the level of direct engagement with individual parts of the system without the agreement of the ICS.

Planning

- The ICS and the regional team will work in partnership to review and mutually assure place- and organisation-based operating plans within the system.

- This review is expected to result in jointly agreed actions or interventions to support delivery across the system, which will be monitored through oversight arrangements described above.

Other responsibilities and flexibilities

- The ICS will actively participate in the design of the regional operating model.
- NHS England and NHS Improvement will offer development programmes to ICSs to support their further maturity and development. NHS England and NHS Improvement and the ICS will jointly agree the nature and objectives of such programmes and will work together to maximise their impact on ICS development.
- NHS England and NHS Improvement commit to minimising the administrative burden on the ICS and its constituent parts. In particular, NHS England and NHS Improvement and the ICS intend that the arrangements of this Memorandum should not introduce an additional layer of reporting or bureaucracy. As the arrangements of this Memorandum develop and embed over time, we will work together to further reduce the burden for the benefit of all parties.

6. Review

This Memorandum will be reviewed periodically by NHS England and NHS Improvement and the ICS. In particular:

- The financial framework will need to be updated for the year 2020/21 and beyond;
- It is expected that the ICS will continue to develop and mature, which will enable the parties to agree revised system responsibilities and flexibilities;
- The Memorandum will be reviewed annually from the date of signature or the date of the last review, or at a time jointly agreed by the signatories. The update to the financial framework for 2020/21 will constitute a review of the Memorandum only if the entire Memorandum is reviewed at that time.

Signature

[signature and date]

Fiona Wise, ICS Lead, confirms collective agreement of BOB ICS system leaders

[signature and date]

Anne Eden, Regional Director, on behalf of NHS England and NHS Improvement

Appendix 1

Transformation Funding Table

Buckinghamshire, Oxfordshire and Berkshire West		
ICS Transformation Funding	**2019/20 £m**	**Requirements/notes**
Primary Care		
GP Retention	**0.375**	Confirmed fair share allocations from the Primary Care team Expectations set out in the Long Term Plan GP Access funds to be allocated as part of a separate process so excluded from this breakdown Other targeted Primary Care allocations to be notified separately
Reception & Clerical Training	**0.311**	
Practice Resilience	**0.236**	
Online Consultations	**0.506**	
Primary Care Networks	**1.293**	
Cancer	**3.872**	Expectations in line with Planning Guidance Delivery. Funds allocated to Cancer Alliances
Mental Health	**6.235**	Perinatal and Adult Mental Health (AMH) programmes
Maternity	**1.070**	Expectations in line with LTP objectives. Funds allocated to Local Maternity Systems (LMS's)
STP Infrastructure Support	**0.290**	STP infrastructure support - available to ICS areas co-terminus with STPs
Diabetes	**0.653**	Diabetes LTP funding
ICS Flexible Transformation Funding	**3.834**	Uncommitted / Flexible funding in line with values last year for each ICS
TOTAL	**18.676**	

Appendix 2 Control Total Tables

As described in section 4, organisational system control totals have been set for BOB for 2019/20, with a notional system control total.

Table 1: Organisation control total and PSF, FRF, MRET, CSF allocations

Org Name	Included in SCT	Control Total (excl. MRET, FRF, PSF/CSF) (£000s)	Total PSF/CSF/FRF/MRET Allocation (£000s)
Berkshire Healthcare NHS Foundation Trust	60%	(242)	1,382
Buckinghamshire Healthcare NHS Trust	100%	(18,561)	18,561
Oxford Health NHS Foundation Trust	100%	(4,755)	4,755
Oxford University Hospitals NHS Foundation Trust	100%	7,578	30,290
Royal Berkshire NHS Foundation Trust	100%	(1,497)	12,184
South Central Ambulance Service NHS Foundation Trust	50%	(1,070)	1,070
NHS Berkshire West CCG	100%	0	0
NHS Buckinghamshire CCG	100%	(15,000)	10,000
NHS Oxfordshire CCG	100%	0	0
System Total		**(33,547)**	**78,242**

Table 2: Quarterly phasing of the control total (excl. PSF, FRF, MRET, CSF) and PSF, FRF, MRET, CSF allocations for each organisation

Org Name		Q1 (£000s)	Q2 (£000s)	Q3 (£000s)	Q4 (£000s)	2019/20 Total (£000s)
Berkshire Healthcare NHS Foundation Trust	CT	(470)	90	318	(180)	**(242)**
	PSF	208	277	415	482	**1,382**
	FRF	0	0	0	0	**0**
	MRET	0	0	0	0	**0**
	Total PSF/FRF/MRET	**208**	**277**	**415**	**482**	**1,382**
Buckinghamshire Healthcare NHS Trust	CT	(4,935)	(4,506)	(4,522)	(4,598)	**(18,561)**
	PSF	872	1,163	1,745	2,036	**5,816**
	FRF	1,283	1,711	2,567	2,995	**8,556**
	MRET	1,047	1,047	1,047	1,048	**4,189**
	Total PSF/FRF/MRET	**3,202**	**3,921**	**5,359**	**6,079**	**18,561**
Oxford Health NHS Foundation Trust	CT	(2,393)	(2,096)	(1,681)	1,415	**(4,755)**
	PSF	434	579	869	1,014	**2,896**
	FRF	279	372	558	650	**1,859**
	MRET	0	0	0	0	**0**
	Total PSF/FRF/MRET	**713**	**951**	**1,427**	**1,664**	**4,755**
Oxford University Hospitals NHS Foundation Trust	CT	(6,497)	669	4,368	9,038	**7,578**
	PSF	2,150	2,866	4,300	5,016	**14,332**
	FRF	0	0	0	0	**0**
	MRET	3,990	3,990	3,990	3,988	**15,958**
	Total PSF/FRF/MRET	**6,140**	**6,856**	**8,290**	**9,004**	**30,290**
Royal Berkshire NHS Foundation Trust	CT	(4,595)	511	1,203	1,384	**(1,497)**
	PSF	1,053	1,404	2,106	2,456	**7,019**
	FRF	0	0	0	0	**0**
	MRET	1,291	1,291	1,291	1,292	**5,165**
	Total PSF/FRF/MRET	**2,344**	**2,695**	**3,397**	**3,748**	**12,184**
South Central Ambulance Service NHS Foundation Trust	CT	(161)	(214)	(321)	(374)	**(1,070)**
	PSF	133	177	264	308	**882**
	FRF	28	38	56	66	**188**
	MRET	0	0	0	0	**0**
	Total PSF/FRF/MRET	**161**	**215**	**320**	**374**	**1,070**
NHS Berkshire West CCG	CT	0	0	0	0	**0**
	CSF	0	0	0	0	**0**
NHS Buckinghamshire CCG	CT	(3,750)	(3,750)	(3,750)	(3,750)	**(15,000)**
	CSF	1,000	2,500	3,000	3,500	**10,000**
NHS Oxfordshire CCG	CT	0	0	0	0	**0**
	CSF	0	0	0	0	**0**
System CT Total		(22,901)	(9,296)	(4,365)	2,935	(33,547)
PSF/CSF/FRF Total		7,440	11,087	15,880	18,523	52,930
MRET Total		6,328	6,328	6,328	6,328	25,312

Appendix 3 System Responsibilities and Flexibilities

ICS progression

	Emerging	Developing	Maturing ICS *System formally named an ICS and minimum level of maturity for all systems to reach by April 21*	Thriving ICS
Oversight	• Systems can provide advice and guidance on individual organisations within the system to support conversations	• Systems will develop and implement a plan to support ICS development, which will be reviewed and agreed with NHSEI	• ICSs will agree and implement system-wide objectives agreed with regional teams, covering care quality and health outcomes, reductions in inequalities, implementation of integrated care models and improvements in financial and operational performance • ICSs will conduct and contribute to the assurance and improvement of individual organisations performance	• ICSs will lead the assurance of all individual organisations • ICSs will agree and coordinate any trust or CCG intervention carried out by NHSEI, other than in exceptional circumstances • ICSs will be able to lead and shape how gathering any data from individual organisations is managed where required
	• NHSEI will use a single performance, oversight and assessment framework	• NHSEI will invite system leadership to attend and contribute to discussions relating to individual organisations within the system • NHSEI will consult the system position before any escalation action/ intervention is approved and enacted through a single identified lead • NHSEI will align roles within the regions to support systems	• NHSEI will keep ad hoc data requests and routine reporting outside the performance framework and agreed ICS objectives to a minimum, and coordinate through an identified lead • NHSEI will not engage with individual Trusts or CCGs without the knowledge of the ICS • NHSEI will co-locate regional roles within the ICS to provide bespoke support requested by the ICS	• NHSEI will agree a minimum dataset with ICSs • NHSEI will embed regional resources within the ICS to operate under the direction of the ICS • NHSEI will undertake the least number of formal assurance meetings possible with individual organisations
Finance		• STPs will demonstrate strong financial leadership and governance for financial decision-making	• ICSs will take up the 19/20 ICS financial framework • ICSs will commit to delivering the objectives of the relevant national programmes and report progress against this. Appropriate governance arrangements to account for use of funds will be in place before any funds are released • NHSEI will delegate authority for the distribution of transformation funding from national programmes to the system, where possible	• ICSs will take up the 19/20 ICS financial framework
Planning	• Organisational financial recovery plans will be developed with the system leaders to ensure consistency with five year system-level strategic plans, with system efficiency plans overseen by a system efficiency board		• Organisations that are in financial surplus will play an active role in the development and delivery of financial recovery plans of organisations within their ICS	• ICSs will lead assurance of organisational plans • System operating plans will have a light touch review by the NHSEI
	• NHSEI will lead review and assurance of organisational and system operating plans • NHSEI will work with the system to develop and strengthen these plans	• NHSEI will work in partnership with system leaders to review organisational and system operating plans	• NHSEI will support system leaders to assure organisational plans, and will work in partnership with system leaders to ensure system operating plans are sufficiently robust	
Support	• Intense support, regionally led and nationally coordinated	• Based on needs identified in development plan • ICS Accelerator Programme TBC • Access to regional and national subject-matter expertise where required	• ICS Development Programme	• ICS Development Programme • Expectation to work alongside regional and national teams to support less developed systems

(1) NHS Berkshire West CCG

(2) NHS Buckinghamshire CCG

(3) NHS Oxfordshire CCG

ESTABLISHING JOINT WORKING ARRANGEMENTS FOR COMMISSIONING IN THE BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST (BOB) INTEGRATED COMMISSIONING SYSTEM

TERMS OF REFERENCE FOR

1. A Joint Committee for CCG Commissioning Decisions

1. INTRODUCTION AND RATIONALE

Through our joint working as part of the BOB ICS the three CCGs have committed to, where appropriate, undertaking some Commissioning decisions at scale. This needs to be supported by appropriate governance arrangements.

2. The proposals in this document cover:

2.1. The development of a joint committee to enable joint decision making where we are commissioning at scale across the 3 CCGs. This committee will also provide a forum to:

2.1.1. Discuss clinical standards with a view to reducing variation thresholds across the BOB footprint.

2.1.2. Receive and consider recommendations from the ICS Programme Workstreams where decisions are required to formally enact changes

3. Recommendation

3.1. The CCGs agree to the establishment of a joint committee to enable them to take certain decisions jointly under section 14Z3 (2)(b) of the National Health Service Act 2006

3.2. Should agreement be provided by all three CCGs during November 2019 then the CCGs agree to hold the first meeting of this Joint Committee in January 2020, following the adoption of the changes required to CCG Constitutions.

Joint Committee for CCG Commissioning

Terms of Reference

1 Context

1.1 Health leaders within the Berkshire West, Oxfordshire and Buckinghamshire (BOB) Integrated Care System (ICS) have collectively committed to changing the way certain elements of health care are commissioned and provided to the local population in order to deliver the highest quality of care possible within the resources available.

1.2 Further thereto, the NHS Berkshire West CCG, the NHS Buckinghamshire CCG and the NHS Oxfordshire CCG ("the CCGs") have agreed to work together in a formal arrangement through the establishment of a joint committee using their powers under Section 14Z3(2)(b) of the National Health Service Act 2006 to enable them to take certain commissioning decisions jointly.

1.3 The CCGs will thereby be better able to shape strengthened strategic commissioning at a BOB ICS level. This will create a single strategic commissioning forum that can deliver improved outcomes across a bigger geographical footprint, whilst retaining the ability to respond sensitively to its local communities.

1.4 Individual CCGs will still always remain accountable for meeting their statutory duties. The aim of creating a joint committee is to encourage the development of strong collaborative and integrated relationships and decision-making between partners.

2 Establishment

2.1 The Governing Body of each of the CCGs has agreed to the establishment of a joint committee with delegated authority for decision-making.

2.2 The Joint Committee will be known as 'the CCG Joint Committee'. The CCG Joint Committee is accountable to each of the Boards/Governing Bodies of the constituent CCGs.

3 Members of the Joint Committee

3.1 The core Membership of the CCG Joint Committee will comprise:

3.1.1 The Clinical Chairs of each CCG, one of whom to be elected by the CCG Joint Committee as the Chair for a period of 12 months and one of whom to be elected as the Deputy Chair, hereinafter the chairmanship and deputy chairmanship shall rotate on an annual basis;

3.1.2 A Lay Member from each CCG;

3.1.3 The Accountable Officers of each CCG;

3.1.4 A director from each CCG to between them cover Finance, Commissioning and Quality. The inaugural meeting of the committee will agree a proposal with regard to the specific membership which will be reviewed from time to time as is appropriate.

Should the BOB ICS Lead be an individual who does not hold any of the roles specified above then this person shall be invited to attend the meeting as a standing invitee.

The secretariat to the Joint Committee will be provided in a manner to be determined collaboratively by the three CCGs.

3.2 Members of the CCG Joint Committee may nominate a suitable deputy when necessary and subject to the approval of the Chair. All deputies should be fully briefed and the secretariat informed of any agreement to deputise so that a quorum can be maintained.

The deputising arrangements for the managerial members of the Committee are as follows:

Committee Member	**Deputy**
Accountable Officer	Deputy Chief Officer from relevant CCG
Standing Chief Finance Officer	Chief Finance Officer from either of the remaining CCGs
Standing "Commissioning Director" (or equivalent)	Director of Commissioning or Deputy Chief Officer from either of the remaining CCGs
Director of Nursing (or equivalent)	Director of Nursing from either of the remaining CCGs

3.3 The following members shall be present for the Joint Committee to be considered quorate:

- The Chair and one other Clinical Chair
- Two CCG Lay Members
- All Accountable Officers (or nominated deputies)

4 Principles

4.1 In performing their respective obligations under this Agreement and commissioning contracts, the CCGs must:

4.1.1 at all times act in good faith towards each other;

4.1.2 act in a timely manner;

4.1.3 share information and best practice, and work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost;

4.1.4 at all times, observe relevant statutory powers, requirements and best practice to ensure compliance with applicable laws and standards including those governing procurement, data protection and freedom of

information, and the Nolan principles and Standards for CCG Governing Bodies; and

4.1.5 have regard to the needs and views of all of the CCGs, and as far as is reasonably practicable take such needs and views into account while meeting their individual statutory obligations

5. Role of Joint Committee

5.1 The CCG Joint Committee shall

Assume delegated responsibility for those commissioning functions of each CCG specified in Section 6 and so be responsible for strategy, performance and governance for those issues within the remit of the Joint Committee.

6. Functions of the Joint Committee

6.1 The principal function of the CCG Joint Committee is to enable the CCGs where appropriate to act collectively in the planning, securing and monitoring of health and care services to meet the needs of the populations of Berkshire West, Oxfordshire and Buckinghamshire.

6.2 The functions of the CCG Joint Committee will include:

6.2.1. Decisions on relevant service configurations;

6.2.2 Leadership of relevant public consultations on significant service changes that affect the whole area;

6.2.3 Agreement of new commissioning policies, including those originating from the Thames Valley Priorities Committee

6.2.4 Agreement of relevant outcomes, frameworks and pathways;

6.3 The Joint Committee will also have delegated responsibility for commissioning of services on behalf of the CCGs as follows:

6.3.1 The South Central Ambulance Contract for provision of the 999 service;

6.3.2 The jointly procured Thames Valley Integrated Urgent and Emergency Care (IUEC) Contract;

6.3.4 Sign off common commissioning frameworks (e.g. quality)

6.4 For such contracts the CCG Joint Committee will ensure there are appropriate arrangements in place to:

6.4.1 Develop the commissioning strategy for the areas delegated, including where relevant setting commissioning intentions and desired outcomes;

6.4.2 Establish and manage contracts for the areas/services delegated;

6.4.3 Monitor the delegated commissioning contracts, including in respect of quality standards, observance of service specifications, and monitoring of activity and finance, so as to obtain best performance, quality and value from the Services by assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

6.4.4 Agree variations to the commissioning contracts or services in

accordance with national policy, service user needs and clinical developments;

6.4.5 Oversee the procurement of services in line with commissioning decisions and manage risk associated with such procurements;

6.5 The CCGs' Governing Bodies may decide, from time to time, to delegate additional functions to the CCG Joint Committee, in which case these terms of reference shall be updated as necessary.

7 Decision-making

7.1 The CCG Joint Committee will have delegated responsibility to make decisions that bind the CCGs in relation to those commissioning functions delegated to the Joint Committee.

7.2 The members of the CCG Joint Committee will aim to make decisions by consensus wherever possible. Where this is not achieved, a decision will be made by a vote of those present.

7.3 Each CCG (regardless of numbers of representatives/members present) has one vote. A decision is confirmed when there is either a unanimous vote or two votes are cast in favour.

7.4 Each CCG is responsible for ensuring that its nominated members to the Joint Committee have sufficient delegated authority, in accordance with that CCG's constitution, to act on behalf of that CCG within the remit of the Committee;

8 Meetings

8.1 At all times the members of the CCG Joint Committee will act in accordance with the terms of their respective constitutions. No decision or outcome shall impede any organisation in the fulfilment of its statutory duties.

8.2 Each CCG member retains its own decision-making accountability and exercises its powers concurrently with the others through the meetings of the CCG Joint Committee where members meet together to discuss, debate and make decisions in relation to their joint working.

8.4 Decisions taken by the Joint Committee will be communicated back to CCG Governing Bodies for information. As the Joint Committee will be operating with the authority of delegated decision making, CCG Governing Bodies will not be required to ratify the decisions of the Joint Committee.

8.5 As a separate committee with fully delegated authority from its own Governing Body, each member will bind its organisation so that when they meet together as the Joint Committee decisions are final.

8.6 Meetings of the CCG Joint Committee shall initially be held in private but once the joint working arrangements are agreed, meetings will be held in public unless the Joint Committee resolves that it would not be in the public interest to permit members of the public to attend a meeting or part of a meeting in accordance with the Public Bodies (Admission to Meetings) Act 1960. The Joint Committee will produce an annual report setting out the work it has undertaken and the

decisions which have been made during that period.

8.7 Members of the CCG Joint Committee have a collective responsibility for its operation. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

8.8 The CCG Joint Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

8.9 The CCG Joint Committee has the power to establish sub groups and working groups and any such groups will be accountable directly to it.

8.10 Members of the CCG Joint Committee shall respect confidentiality requirements at all times.

9 Frequency of Meetings

9.1 The CCG Joint Committee shall meet at such times and places as the Chair may direct on giving reasonable written notice to the members but will meet at least quarterly.

9.2 Special meetings of the CCG Joint Committee may be called by any member, with the agreement of the Chair, by giving at least 48 hours' notice to each member.

10. Participation in Meetings

10.1 The Chair may agree that the members of the Joint Committee may participate in meetings by means of telephone, video or computer link or other live and uninterrupted conferencing facilities. Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting for quoracy and other purposes.

11. Conflicts of Interest

11.1 All CCG Joint Committee members are required to make an annual declaration of relevant and material interests. The register of interests will be regularly reviewed and where necessary updated.

11.2 If, at any meeting or during the course of a CCG Joint Committee, a member has a conflict of interest or a potential conflict of interest in relation to the scheduled or likely business for the meeting, he or she shall declare the conflict of interest or potential conflict of interest to the Chair of the meeting.

11.3 It is the responsibility of individual members to declare any new conflict or potential conflict in relation to a decision to be made by the CCG Joint Committee as soon as they become aware of it, and in any event within 28 days.

11.4 For the avoidance of doubt the provisions of the NHS England statutory guidance 'Managing Conflicts of Interest for CCGs' or any successor

documents will apply at all times.

12. Administrative

12.1 The papers for each meeting will be sent to the members no later than 5 working days prior to each meeting and earlier if possible. By exception, and only with the agreement of the Chair, may papers be tabled before the meeting.

12.2 The costs of operation of the CCG Joint Committee will be met equally by the CCGs.

13. Reporting

13.1 The Chair shall arrange for a copy of the approved minutes for each meeting, once approved ('the Approved Minutes') to be sent to the members.

13.2 The CCG Accountable Officers shall be responsible for ensuring that their respective Governing Bodies receive a copy of the Approved Minutes.

13.3 The CCG Joint Committee through its Chair will make an annual written report to the CCGs' Governing Bodies and hold at least annual engagement events to review aims, objectives, strategy and progress.

14. Review of Terms of Reference

14.1 These terms of reference will be formally reviewed by the Governing Bodies of the CCGs on an annual basis, taking the date of the first meeting, following the year in which the Joint Committee is created and may be amended by mutual agreement between the CCGs at any time to reflect changes in circumstances.

(1) NHS Berkshire West CCG

(2) NHS Buckinghamshire CCG

(3) NHS Oxfordshire CCG

ESTABLISHING JOINT WORKING ARRANGEMENTS FOR COMMISSIONING IN THE BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST (BOB) INTEGRATED COMMISSIONING SYSTEM

TERMS OF REFERENCE FOR

1. **BOB ICS Primary Care Board**
2. **BOB ICS Specialised Commissioning Planning Board**

1. Introduction & Rationale

Through our joint working as part of the BOB ICS the three CCGs have committed to, where appropriate undertaking some Commissioning activities at scale. This needs to be supported by appropriate governance arrangements.

2. The proposals in this document cover:

2.1. The establishment of a BOB ICS Primary Care Board, which has already taken effect. This Board has now taken *de facto* responsibility and oversight of the Primary Care Transformation funding that is allocated to the ICS. Terms of reference for this Board are therefore included within this document and presented to Governing Bodies in order to formalise the current working arrangement. This Board will not replace the local Primary Care Commissioning Committees within each CCG, which will continue to support local decision making mainly associated with place based GP practices.

2.2. The development of a Specialised Commissioning Planning Board in collaboration with NHS England, adopting the “seat at the table” approach which has already been established in other parts of the country.

2.3.

3. Recommendation

3.1. To discuss and feedback on the draft Terms of Reference.

Buckinghamshire, Oxfordshire and Berkshire West ICS

Primary Care Programme Board

TERMS OF REFERENCE

1. Purpose

- The Primary Care Programme Board ("the Programme Board") has been established by the 3 CCGs in BOB ICS to provide a forum for co-operation and collaboration across the footprint. Its core purpose is to provide a structure through which CCGs can support one another to successfully deliver their local primary care strategy.

- The CCGs in BOB ICS have agreed that the Programme Board will co-ordinate a number of work streams on behalf of all CCGs. These areas have been selected on the basis that working together is likely to be more effective in delivering local plans than each CCG working alone.

2. Status and authority

- As the purpose of the Programme Board is principally to co-ordinate activities, it does not have the authority to take decisions about resources that will bind an individual CCG.

- In order to ensure the Programme Board is effective, each CCG will need to ensure that its representatives on the Programme Board have sufficient delegated authority/seniority to enable the Programme Board to function effectively in discharging its duties within these Terms of Reference.

3. Responsibilities

- The Programme Board will:

  (a) promote and champion primary care within the BOB ICS system, as well as regionally and nationally;

  (b) provide mutual support to the CCGs to implement the agreed primary care strategy and each CCGs' local implementation plan;

  (c) oversee a small number of shared work streams (initially identified as workforce, estates, digital and organisational development/leadership);

  (d) agree ICS wide work programmes, bids or returns on behalf of the CCGs (e.g. estates/capital submissions) and where relevant/necessary secure formal sign off from each CCG;

  (e) on behalf of the CCGs, liaise directly with the regional and national teams of NHSE on matters that are ICS wide, including:

    - Primary care estate;
    - Implementation of the GP Forward View; and
    - developing initiatives that will benefit primary care, the CCGs and the wider system

(f) take an overview of the financial position for primary care in BOB ICS , including tracking investment against the agreed financial plan;

(g) where relevant, develop bids for additional funds for investment in primary care across BOB ICS, and where required ensure sign off/ratification by each CCG;

(h) develop a proposed approach to the oversight, deployment and administration of any pooled ICS funds, for ratification for CCG Boards

(i) provide a forum for supporting the development of localities/neighborhoods and for practices to influence the strategic direction;

(j) ensure that there is a forum for other system partners to liaise with each CCG on matters that affect primary care (e.g. development of strategic plans);

(k) provide a forum for sharing innovation and best practice.

(l) provide an opportunity for NHSE, PHE and CCG commissioners to work together across the primary care agenda and develop a joint approach to commissioning the full range of primary care

4. **Accountability**

- The Programme Board is accountable to BOB ICS System Leaders Group.

- It is anticipated that members of the Programme Board will ensure that their respective Boards or equivalent are regularly briefed on discussions and decisions taken at the Programme Board.

- Update reports will be provided to the ICS System Leaders Group quarterly and this will also be made available for Primary Care Commissioning Committees at a CCG level.

- The Programme Board may establish sub groups where it is agreed that the CCGs should work together on a single programme. These sub groups will be accountable to the Programme Board. In the first instance, the workforce sub group will report to the Programme Board. The Programme Board will also receive a report from the ICS Estates Group and a progress report on Digital.

- The minutes of the Programme Board will be sent to the participants within 10 working days of each meeting.

5. Membership and Quorum

The membership of the Programme Board will include the following:

- ICS Chief Executive Sponsor (Chair)
- Clinical Chairs of each of the CCGs (or their nominated clinical lead/deputy)
- Director/Head of Primary Care from each CCG
- LMC representative
- The ICS Primary Care Finance Lead
- Chairs of any sub-groups

- GPFV SRO
- Director of Commissioning NHSE/Head of Commissioning NHSE
- PHE representative

- The Programme Board may invite additional members that it considers necessary to achieve its objectives. The intention is to retain a degree of flexibility in membership, ensuring that established and emerging clinical leaders have the opportunity to participate.

- The Programme Board will be quorate if two thirds of its members are present, subject to the members present being able to represent the views and decisions of the members who are not present at any meeting.

- The Programme Board will be chaired by Cathy Winfield Chief Officer Berkshire West CCG and BOB ICS Chief Executive Sponsor Primary Care and the Co Chair will be Kiren Collison Clinical Chair, Oxfordshire CCG .

- Where the Chair is absent, the Co Chair shall take on the role of the Chair.

6. Conduct of Business

- Meetings will be held Monthly.

- The agenda will be developed in discussion with the members of the Programme Board and its work programme. Circulation of the meeting agenda and papers via email will take place approximately one week before the meeting is scheduled to take place. If members wish to add an item to the agenda they need to notify the Chair or SRO accordingly.

- At the discretion of the Chair a decision may be made on any urgent matter within these Terms of Reference through the written approval of every member listed in Section 5 of this document. Such a decision shall be as valid as any taken at a quorate meeting but shall be reported for information to, and shall be recorded in the minutes of, the next meeting.

7. Decision Making and Voting

- The Programme Board will aim to achieve consensus for all decisions of the Participants.

8. Conflicts of Interests

- The members of the Programme Board must refrain from actions that are likely to create any actual or perceived conflicts of interests. Conflicts of interest will be recorded at each meeting and managed appropriately

9. Confidentiality

- Members of the Programme Board are expected to protect and maintain as confidential any privileged or sensitive information divulged during the work of the Programme Board. Where items are deemed to be privileged or particularly sensitive in nature, these should be identified and agreed by the Chair. Such items

should not be disclosed until such time as it has been agreed that this information can be released.

10. Support

- Support to the Programme Board will be provided by the GPFV SRO.

- The programme structure and supporting work groups will be developed and agreed as part of the Programme Board work plan.

11. **Review**

- These terms of reference will be formally reviewed annually.

Buckinghamshire, Oxfordshire and Berkshire West ICS

Specialised Services Planning Board

TERMS OF REFERENCE

1. Purpose

This document details the Terms of Reference for the Specialised Commissioning Planning Board ('the Board').

2. Context

In July 2019 Buckinghamshire, Oxfordshire, Berkshire West STP was announced as a 'Wave 3 ICS'. As a part of the progression to an ICS NHS England expect that the CCGs within the ICS footprint will work more collaboratively together in understanding their populations and strategically commission appropriately. Implementation of a Specialised Services Planning Board across the ICS footprint offers the opportunity to:

- create the conditions for Buckinghamshire, Oxfordshire & Berkshire West to operate as a system with aligned incentives
- influence more aspects of population based transformation for specialised services
- enable different approaches to the funding of innovation and transformation, including for longer term 'invest to save' propositions.

The BOB ICS has a population of 1.8 million with significant spend on specialised service provision across all providers. There is therefore an opportunity for greater joint working at place and scale on the future strategy of specialised services.

Through the collaboration of place based organisations, key specialised services will be identified for a greater focus. The selected specialised services will be identified collaboratively and tracked through the Board on an ongoing basis.

Work will also be undertaken to address service reconfiguration and greater integration of services between organisations when it is appropriate to do so.

The Board will not have formal decision-making powers as statutory responsibilities will remain with NHS England, having due regard to the statutory bodies which comprise the BOB ICS and taking their views into account through engagement and collaboration. This approach is often referred to as the 'seat at the table' way of working as developed within the Surrey Heartlands ICS and is referenced as such from hereon in.

Role of the Board

The role of the Specialised Commissioning Planning Board is to enable shared decision making at place and scale through system wide collaborative working to transform and improve services for local patients by:

- improving quality, outcomes and access
- ensuring services maximise clinical and financial resources within the BOB ICS
- Identify alignment of opportunities to improve specialised services through joint planning and the development of integrated pathways.

The Board will bring together existing NHSE specialised commissioning expertise with Buckinghamshire, Oxfordshire & Berkshire West provider and commissioner expertise to enable a collaborative partnership approach to be adopted. This approach, often referred to as the 'seat at the table' way of working will enable progression for the improvement of specialised services and their value for money across the BOB geography.

3. Responsibilities

The responsibilities of the Specialised Commissioning Planning Board include:

- Developing potential opportunities for the devolution of specialised services where these can demonstrably improve quality, outcomes or value for money
- Providing oversight of the identified priority work programmes and delivery milestones through assurance provided by the underpinning workstreams.
- Making recommendations for action to the Buckinghamshire, Oxfordshire & Berkshire West CCGs in relation to Specialised Commissioning transformation, commissioning and devolution.
- Leading on the longer-term integrated delivery structure and framework.
- Leading the development of end to end pathway collaboration and integration.
- Reporting progress against the implementation plan to the Buckinghamshire, Oxfordshire & Berkshire West CCGs.
- Providing assurance to NHSE South East Region of progress against agreed deliverables.
- Skills and knowledge transfer through alignment of posts between Specialised Commissioning and the commissioning architecture to enable increased influence, capacity and capability in specialised commissioning.
- Promoting and supporting engagement across Buckinghamshire, Oxfordshire & Berkshire West to ensure that the views of all relevant stakeholders, including citizens, are given due weight and consideration in any redesign work.

4. Governance

The Board will be Chaired by the Regional Director of Commissioning from NHS England (South East Region)

Each member is responsible for communicating key decisions and actions back to the formal meetings of their own organisations and/or Integrated Care Partnership Board.

The Board will report through the existing ICS delivery and assurance oversight architecture to the System Leaders Group and Delivery Oversight Group.

The Board will not take formal decisions but will make recommendations for action. It will collaboratively ensure that the views of Buckinghamshire, Oxfordshire & Berkshire West are taken into account when NHSE South East Region makes formal decisions through its formal governance process.

The Regional Director of Specialised Commissioning (or where required delegated to alternative deputy or individual) will retain the NHS England Specialised Commissioning decision making authority and will act as the decision making interface for specialised services between organisations with Buckinghamshire, Oxfordshire & Berkshire West and relevant stakeholders.

5. Membership of the Board

The proposed membership of the Specialised Commissioning Planning Board is set out below:

- NHS England (South East Region) Director of Commissioning – Chair
- Buckinghamshire CCG Accountable Officer
- Oxfordshire CG Accountable Officer
- Berkshire West CCG Accountable Officer
- NHS England (South East Region) Medical Director
- A nominated clinical representative from a CCG within the ICS
- A nominated clinical representative from an NHS acute provider within the ICS
- A nominated Chief Financial Officer from the BOB ICS Finance Oversight Group

* NB – the post-holder for the role of Accountable Officer in Oxfordshire and Buckinghamshire are currently the same individual.

The inaugural meeting of the Board will identify additional members, including provider representatives

Board Members may send a named deputy to attend the Specialised Commissioning Planning Board.

Administrative support will be agreed by the parties to support the effective management of the Board.

Quoracy

No business will be transacted unless the following are present:

- Chair or nominated Deputy

- A representative from each of the Buckinghamshire, Oxfordshire & Berkshire West CCGs
- The Regional Director of Commissioning from NHS England (SE Region)

6. Frequency of Meetings

Meetings will take place quarterly. On occasion, exceptional meetings may be called, including by teleconference, subject to the agreement of the Chair.

7. Administration of Meetings

Agendas and any meeting papers will be emailed at least three days prior to the Board meeting.

Draft meeting minutes and action log will be circulated after approval is given by the Chair.

8. Confidentiality

No member of the Specialised Commissioning Planning Board shall disclose publicly: any information disclosed or discussed at, or in the period between, meetings of the Board, which should reasonably be regarded as confidential; any other information which is not publicly available including, but not limited to, any information specifically designated as confidential; any information supplied by a third party in relation to which a duty of confidentiality is owed or arises; and any other information which should otherwise be reasonably regarded as possessing a quality of confidence or as having commercial value.

For the avoidance of doubt, this requirement of confidentiality does not apply to (1) release of information required by law or at the request of regulators or appropriate public interest disclosures or (2) Members sharing feedback and papers from the Board with their Integrated Care Partnership Boards, provided that all those to whom information is shared are also subject to a condition of keeping all such information confidential.

9. Conflicts of Interest

Members of the Specialised Commissioning Planning Board must declare if they have any interests, whether pecuniary or non-pecuniary, as defined below, which relates to the matters being discussed. Individuals will declare any such interest that they have to the Chair as soon as they are aware of it, and in any event no later than 28 days after becoming aware.

When declaring their interests individuals are required to include any circumstance where a **perception** of wrongdoing, impaired judgement or undue influence could occur, whatever the reality of the situation might be.

Should any such interest be declared, the Chair of the Specialised Commissioning Planning Board should exercise discretion as to whether to disqualify that member

from taking any further part, or in any way influencing by proxy or otherwise, discussion on that matter.

A conflict of interest is where an individual has a direct or indirect pecuniary or non-pecuniary interest in a matter that is being discussed. These can be defined as follows:

- A direct pecuniary interest is when an individual may financially benefit from a decision (for example moving services to them from an alternative provider)
- An indirect pecuniary interest is when an individual may financially benefit from a decision though normally via a third party (for example where an individual is a partner, member or shareholder in an organisation that will benefit financially from the consequences of a reconfiguration decision)
- A direct non-pecuniary interest is where an individual holds a non-remunerative or not-for-profit interest in an organisation (for example, where an individual is a trustee of a voluntary provider that is bidding for a contract)
- An indirect non-pecuniary interest is when an individual may enjoy a qualitative benefit from the consequences of a decision which cannot be given a monetary value (for example, a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house.
- In addition, where an individual is closely related to, or in a relationship, including friendship, with an individual in the above categories, this will constitute a conflict of interest.