Health and Social Care Overview and Scrutiny Committee
10 September 2020

Proposed Structure and Governance Arrangements for Devon Integrated Care System

Report of the Lead Chief Executive for the Devon sustainability and transformation partnership (STP)

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1. Introduction and Context

1.1. The NHS Long-Term Plan set the ambition that every part of the country should be an integrated care system (ICS) by 2021. It encourages all organisations in each health and care system to join forces, so they are better able to improve the health of their populations and offer well-coordinated efficient services to those who need them.

1.2. NHS England and NHS Improvement (NHSE/I) set out a consistent approach to how systems are designed highlighting three levels at which decisions are made and described the broad functions to be undertaken at each level:

1.2.1. Neighbourhoods (populations circ. 30,000 to 50,000 people) served by groups of GP practices working with NHS community services, social care and other providers to deliver more coordinated and proactive services through primary care networks (PCNs).

1.2.2. Places (populations circ. 250,000 to 500,000 people) served by a set of health and care providers in a town or district, connecting PCNs to broader services including those provided by local councils, community hospitals or voluntary organisations.

1.2.3. Systems (populations circa 1 million to 3 million people) in which the whole area's health and care partners in different sectors come together to set strategic direction and to develop economies of scale. An ICS is not a legal entity and has no authority and powers other than those afforded it by its constituent sovereign organisations that are the NHS and Local Authority (LA) organisations in the area.
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Level	Functions	Priorities from the NHS Long-Term Plan
Neighbourhood (c.30,000 to 50,000 people)	• Integrated multi-disciplinary teams • Strengthened primary care through primary care networks – working across practices and health and social care • Proactive role in population heath and prevention • Services (e.g. social prescribing) drawing on resource across community, voluntary and independent sector, as well as other public services (e.g. housing teams).	• Integrate primary and community services • Implement integrated care models • Embed and use population health management approaches • Roll out primary care networks with expanded neighbourhood teams • Embed primary care network contract and shared savings scheme • Appoint named accountable clinical director of each network
Place (c.250,000 to 500,000 people)	• Typically council/borough level • Integration of hospital, council and primary care teams / services • Develop new provider models for 'anticipatory' care • Models for out-of-hospital care around specialties and for hospital discharge and admission avoidance	• Closer working with local government and voluntary sector partners on prevention and health inequalities • Primary care network leadership to form part of provider alliances or other collaborative arrangements • Implement integrated care models • Embed population health management approaches • Deliver Long-Term Plan commitments on care delivery and redesign • Implement Enhanced Health in Care Homes (EHCH) model
System (c.1 million to 3 million people	• System strategy and planning • Develop governance and accountability arrangements across system • Implement strategic change • Manage performance and collective financial resources • Identify and share best practice across the system, to reduce unwarranted variation in care and outcomes	• Streamline commissioning arrangements, with CCGs to become leaner, more strategic organisations (typically one CCG for each system) • Collaboration between acute providers and the development of group models • Appoint partnership board and independent chair • Develop sufficient clinical and managerial capacity
NHS England and NHS Improvement (regional)	• Agree system objectives • Hold systems to account • Support system development • Improvement and, where required, intervention	• Increased autonomy to systems • Revised oversight and assurance model • Regional directors to agree system-wide objectives with systems • Bespoke development plan for each STP to support achievement of ICS status
NHS England and NHS Improvement (national)	• Continue to provide policy position and national strategy • Develop and deliver practical support to systems, through regional teams • Continue to drive national programmes e.g. Getting It Right First Time (GIRFT) • Provide support to regions as they develop system transformation teams	

1.3. More recently, "the Phase 3 letter" from NHSE/I received on 31st July 2020 set out the following requirements for systems:

"Working across systems, including NHS, local authority and voluntary sector partners, has been essential for dealing with the pandemic and the same is true in recovery. As we move towards comprehensive ICS coverage by April 2021, all ICSs and STPs should embed and accelerate this joint working through a development plan, agreed with their NHSE/I regional director, that includes:

- Collaborative leadership arrangements, agreed by all partners, that support joint working and quick, effective decision-making. This should include a single STP/ICS leader and a non-executive chair, appointed in line with NHSE/I guidance, and clearly defined arrangements for provider collaboration, place leadership and integrated care partnerships.
- Organisations within the system coming together to serve communities through a Partnership Board, underpinned by agreed

governance and decision-making arrangements including high standards of transparency – in which providers and commissioners can agree actions in the best interests of their populations, based on co-production, engagement and evidence.

- Plans to streamline commissioning through a single ICS/STP approach. This will typically lead to a single CCG across the system. Formal written applications to merge CCGs on 1 April 2021 needed to give effect to this expectation should be submitted by 30 September 2020.
- A plan for developing and implementing a full shared care record, allowing the safe flow of patient data between care settings, and the aggregation of data for population health."

2. Current position in Devon

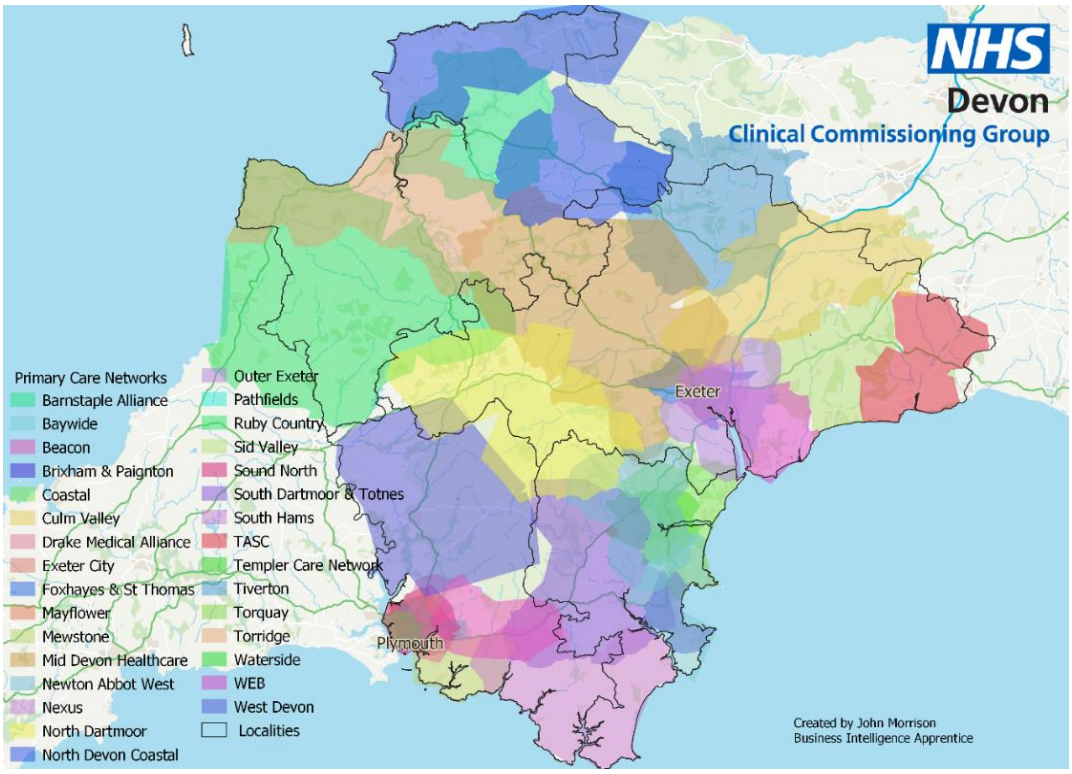
2.1. In Devon this new mechanism for setting strategies and developing and implementing plans to improve the health of a whole population is in the early stages of evolution. At system level Devon is currently a Sustainability and Transformation Partnership (STP), the precursor to an ICS, and has been since 2016.

2.2. NHS England have published a maturity matrix to support the design of integrated care systems (ICSs) in England. The matrix outlines the core capabilities expected of emerging ICSs, developing ICSs, maturing ICSs and thriving ICSs. For a system to be formally named an ICS, they will need to meet the attributes of a maturing ICS1, assessed by the regional office of NHSE/I, which includes delivering performance and financial outcomes that meet plans agreed with NHSE/I. We are anticipating meeting the deadline of April 2021.

2.3. The development of informal structures for working "at place" is also at early stage with different approaches and levels of progress in each of the 5 Local Care Partnership (LCP) areas. There is a clear commitment across the county that place arrangements need to be suited to the circumstances and priorities of each place and there will be no centrally imposed governance structure. However, it is important that each place is able to demonstrate that it has the capacity and capability to deliver on its objectives before it's accountability and budgetary responsibility can be increased. Each LCP has a Development Lead who is co-ordinating and supporting this work.

2.4. From the 1 July 2019, 31 PCNs came into being so creating the "neighbourhood" tier.

[1] https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf



2.5. Each PCN has a Clinical Director and within each LCP there is a Primary Care Collaborative Board that brings together all the PCN Clinical Directors in the area to provide an opportunity for collective consideration of issues as required. In the early stages the priority for PCNs is to offer a way of stabilising primary care and improve access for the population.

3. Developing the Governance and Accountability Arrangements

3.1. It is the role of the ICS to set the governance and accountability arrangements across the system that support each level to fulfil it's function. Consultation with all partners in the ICS has identified a number of principles for these arrangements as set out below:

- System governance needs to be light touch with minimal bureaucracy.
- Arrangements need to be flexible, responsive and emergent.
- The ICS recognises existing and continuing statutory roles and responsibilities.
- The ICS, engaging with all system partners, is responsible for setting strategy, direction and policy. The ICS will make recommendations to statutory organisations where required.
- There is an imperative to establish new arrangements but recognition that initial arrangements may be subject to change pending future NHSE guidance/ gateway criteria. This is an evolutionary process.

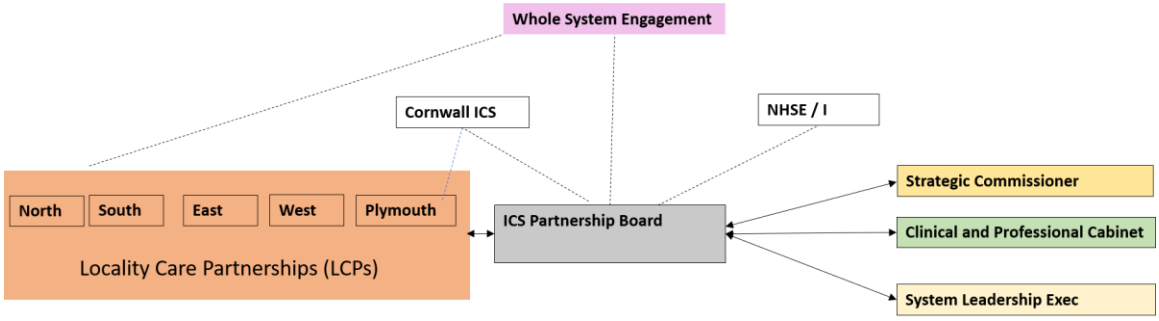
- The principle of subsidiarity is accepted and all partners will hold each other to account for working to this principle. Subsidiarity means that the delivery of integration is happens as close to the citizen as possible - at Place or Neighbourhood. System activity is reserved for when the objectives of an action can be better achieved at system level by reason of the scale and effects of the proposed action or when an action is required by regulators.
- System and place will work together to drive transformation at all levels.
- Meetings will be held virtually whenever possible.

3.2. The overall structure, delivery architecture and governance of an ICS is currently not mandated, and nationally each system is developing its own model. It is possible that there may be some mandated national alignment about the nature and structure of an ICS and all associated governance at a future date but, as outlined in the principles above, the Devon system partners are keen to establish new arrangements to ensure that the momentum and engagement are not lost. Discussions with NHSE/I suggest that the arrangements proposed within this document will be in line with any future requirements.

3.3. Interim governance arrangements were established in 2019 but this way of working was put on hold during the COVID incident. A review of these previous arrangements has been undertaken in light of new approaches to partnership working across health and social care during the COVID incident and there has been an opportunity to learn from past experience, both in Devon and more widely.

3.4. Discussions with individual organisations and their leaders were used to develop a draft structure which was also shaped by a review of arrangements in other systems. This structure was refined through further discussions and two system-wide meetings involving Chairs, Council Leaders, CEOs and place development leaders to produce this document. On 31st July 2020 this group agreed that a Shadow Partnership Board should meet for the first time early in September 2020.

3.5. Following discussion with NHSE/I this document will be socialised more widely with other system stakeholders for feedback before the first Shadow Partnership Board meeting. Subject to approval it will then be shared with organisational Boards and Cabinets for formal approval.



(A more detailed structure is shown at Appendix B)

3.6. The ICS Partnership Board will consist of

- Health Chairs / Council Leaders,
- Health CEOs /Council CEOs
- System CEO
- Chair Clinical and Professional Cabinet

3.7. It will be responsible for:

- Setting system strategy, direction and policy.
- Strategic planning and consideration of the proposed resource allocation
- Strategy Development (e.g. Social Care, Community Care, Procurement (procuring locally))
- Sharing, scaling and spreading good practice
- Solving wicked system issues (such as system infrastructure, competing priorities etc.) and enabling development at place.
- Influencing and strengthening Regional and National links
- Championing Equality and Challenging Inequality
- Citizen Engagement working with Place and individual organisations to prevent duplication of effort.

3.8. The Partnership Board will work closely with the following groups to ensure delivery of system wide objectives and ensure a robust framework for planning and performance management:

- System Leadership Executive
- Clinical and Professional Cabinet
- Strategic Commissioner

3.9. The Partnership will not replicate the Boards or Cabinets of the Health and Social care organisations as its role is not to provide or commission services. There were concerns that if it did in any way replicate those structures that it may start “doing” as opposed to setting a framework for

others to "do" within and create a conflict with the function of LCPs and at neighbourhood with Primary Care Networks (PCNs).

3.10. The Terms of Reference for the Partnership Board are at Appendix A

Working at Place

3.11. Local Care Partnerships (LCPs)will lead the delivery and development of services at place level. Their constituent organisations will take responsibility for a range of functions, previously assigned to providers and commissioners to ensure that services meet the needs of the local population and population health is improved.

3.12. The LCP is an arrangement for joint leadership of multifunctional teams, integrated by a shared plan and objectives, common processes and deployment of joint resources.

3.13. The aims of the LCPs are to

- Deliver Devon system strategies at local level
- Improve health and wellbeing outcomes for the local population
- Reduce inequalities
- Improve people's experience of care
- Improve the sustainability of the health and care system
- Support local engagement including with PCNs

3.14. In order to achieve these outcomes the LCPs will -

- Co-produce plans with ICS Partnership Board which will deliver improved health and care services at population level;
- Develop integrated services;
- Create the conditions for healthy living;
- Manage resources within available budget;
- Plan services through engagement with citizens;
- Develop community assets.

3.15. It is recognised that the success of LCPs will be dependent on a wide network of relationships within a local area. Culture and the approach to working together will be as important as the formal structures. Therefore the membership of the LCP leadership team will be based on local circumstances but should include at a minimum-

- Local Provider Organisations (Health and Care);
- PCN Clinical Directors;
- Local Authorities (officers and elected members) to include social care provision, housing, employment and communities;

- Public Health leadership;
- Community, Voluntary and Social Enterprise Sector;
- Independent Sector.

3.16. LCPs should also be able to demonstrate clearly how they will work with Health and Wellbeing Boards and Scrutiny Committees.

Appendix A

Devon Shadow Integrated Care System Partnership Board

Terms of Reference

1. Introduction and Purpose

1.1. The Integrated Care System (ICS) Partnership Board will be responsible for setting the overarching vision and plan for the Devon Health and Care system and for holding the system accountable for delivery.

2. Aims and Responsibilities

- To agree the Devon Health and Care System strategic vision, ambitions and priorities in line with the Long Term Plan.
- To set the framework within which the system will operate. This will support flexibility for working at place and local decision making whilst having standardised approaches to improving efficiency.
- To consider commissioning intentions, set by the strategic commissioner seeking to influence and align them with system strategic plans and see they are reflected in local Place based plans.
- To inform and engage patients, the public and staff and their representatives in the work of the ICS.
- To consider and give a view on the proposed Capital and Investment Strategy and funding allocations and criteria where required.
- To receive regular update reports from the System Leadership Executive on the ongoing process of delivery of the Long Term Plan and associated delivery plans.
- To agree the Devon ICS Outcomes Framework as developed by the Strategic Commissioner.
- To oversee an annual review of the Long Term Plan and the development of annual delivery plans.
- To hold the system to account for quality and performance.
- To develop strong relationship with Regulators and wider Health and Social Care System and ensure that the system complies with regulatory duties and assurance reporting requirements.
- To develop and maintain relationships with organisations outside Devon where this is appropriate to support delivery of objectives.
- To work across system to promote provider resilience and to co-ordinate response in the event of failure.
- To advise and act upon key strategic issues and risks on performance delivery and transformation of the Devon System.
- To share good practice and promote its spread.
- To provide a forum for solving “wicked issues” .
- To act as the Devon Champion for Equality and Diversity.

3. Membership

- System Independent Chair
- System Chief Executive
- Chief Executive and Chair of all health organisations in the ICS
- Council Leader and CEO of each of the Local Authorities in the ICS
- Chair of the Clinical and Professional Cabinet

4. Frequency

4.1. Meetings will be held monthly and will be planned for the calendar year ahead.

5. Meeting Review

5.1. A review of the efficiency of the ICS Board and delivery of its responsibilities will be undertaken at least annually in line with annual refresh of system governance arrangements. A review of the membership of the Partnership Board will take place roughly six months from the first meeting of the Board.

6. Reporting

6.1. The ICS Partnership Board is accountable to NHSE and NHSI on regulatory and oversight functions currently exercised outside of the system and will report accordingly.

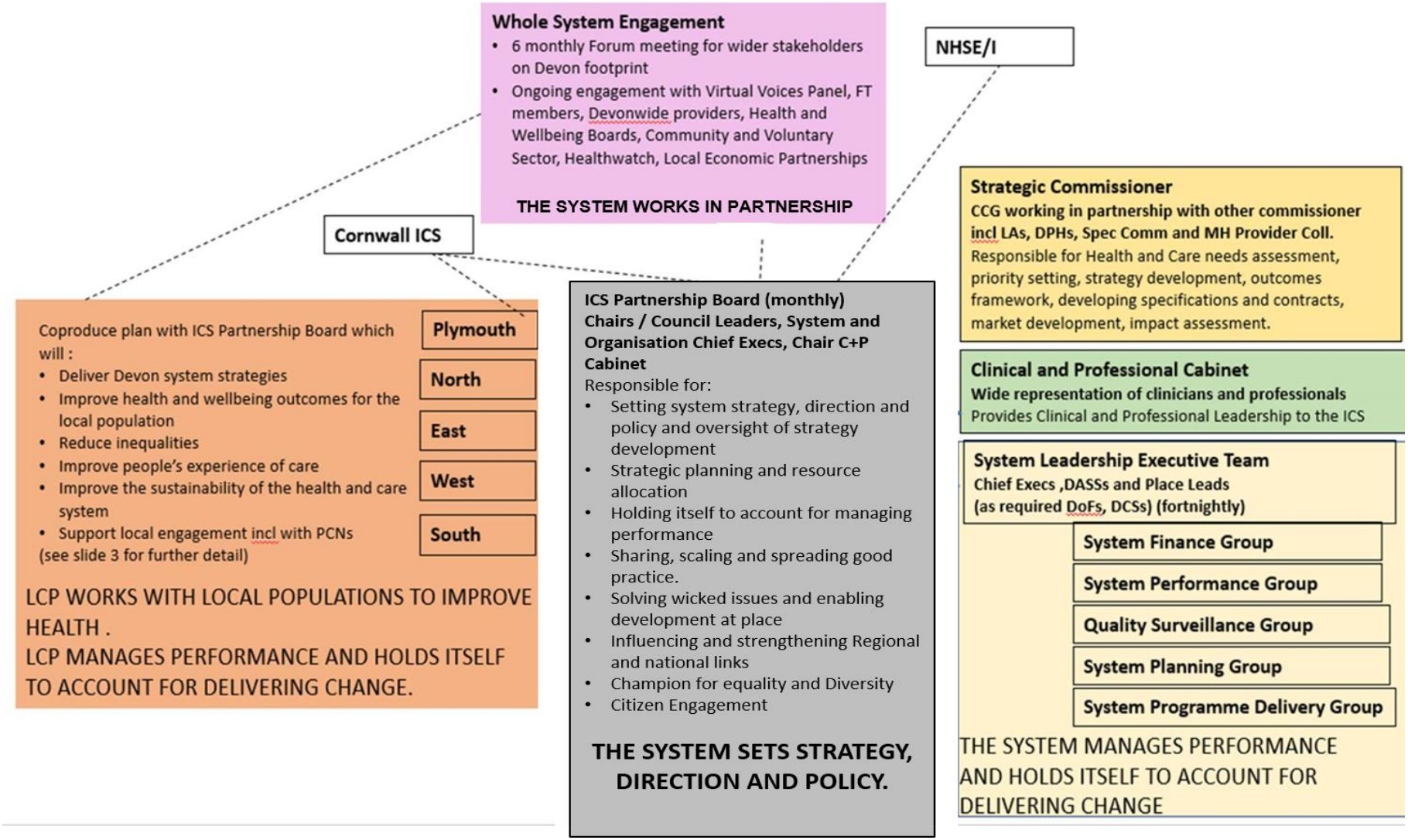
6.2. The ICS Partnership Board is the system's principal governance forum but it is not a statutory body.

6.3. The ICS Partnership Board will operate on the basis of consensus decision making. The Independent Chair will promote this model of working.

6.4. The ICS Partnership Board will work closely with the following groups to ensure delivery of system wide objectives and ensure a robust framework for planning and performance management:

- System Leadership Executive
- Clinical and Professional Cabinet
- Strategic Commissioner

Appendix B – Detailed Governance and Accountability Structure



Electoral Divisions: All Division.

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Local Government Act 1972: List of Background Papers

Background Paper	Date	File Reference
N/A		