Introduction

In order to support Devon to become an Integrated Care System (ICS) several Non – Executive Directors (NEDs) from our NHS Organisations[1] worked with a number of our elected members of our Local Authorities to consider the ICS level governance functions. The work was undertaken through an initial discussion with the NHS NEDs, the creation of a small task and finish group comprising both NEDs and elected members that provided a proposal that was then tested and refined at a much larger group of NEDs and elected members. It is that proposal that we now seek views and support for adoption as our shadow ICS Partnership Board (we cannot call ourselves an ICS until approved by NHSE/I).

Request to NHS Boards and LA Cabinets

1) ***To consider and approve the proposal for the ICS Board and agree to its establishment in "shadow" form in March 2020***

2) ***To consider, approve and agree to sign the Memorandum of Understanding to secure "system" working***

3) ***To consider and approve the system assurance framework as the means of ensuring effective governance of the ICS***

Context

The NHS Long-Term Plan set the ambition that every part of the country should be an ICS by 2021. It requires 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 and sustainable services to those who need them. Integrated care happens when NHS organisations, Local Authorities and other key partners work together to meet the needs of their local population. The most ambitious forms of integrated care aim to improve population health by tackling the causes of illness and the wider determinants of health.

An ICS is not a legal entity, it is a "partnership" of the key statutory agencies bound through a Memorandum of Understanding that work with other key partners in a collaborative manner. Each sovereign organisation maintains their own statutory accountabilities. Governance and any devolved decision-making powers are developed through the partnership.

Framework

NHS England and NHS Improvement (NHSE/I)[2] 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:

DRAFT CONFIDENTIAL

[1] The Non-Executive Directors ensure the Board acts in the best interests of patients and the public. Acting as critical friends, they hold the Board to account by challenging its decisions and outcomes. They also help the Board to formulate strategies, by bringing independent, external perspectives.

[2] NHSE/I NHS England and NHS Improvement work together as a new single organisation to better support the NHS to deliver improved care for patients. Operating through 7 regions (Devon is within the South West) they make decisions about how best to support and assure performance in their region and have a Regulatory function as well as supporting system transformation and the development of sustainability and transformation partnerships and integrated care systems.

- **Neighbourhoods (populations circa 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[3] (PCNs).
- **Places (populations circa 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.
- **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.

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	

Devon

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. The STP operates through a Memorandum of Understanding.

There is an ICS "maturity matrix". The matrix outlines the core capabilities expected of emerging ICSs, developing ICSs, maturing ICSs and thriving ICSs. For a system to be formally designated an ICS, they will need to meet the attributes of a maturing ICS[4], assessed by the regional office of NHSE/I, that will include delivering performance and financial outcomes that meet plans agreed with NHSE/I. We are anticipating meeting the deadline of April 2021.

[3] PCNs are not statutory bodies. They consist of groups of general practices working together with a range of local providers, including across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations. GPs are required to be part of a PCN through their contractual arrangements with NHSE/I

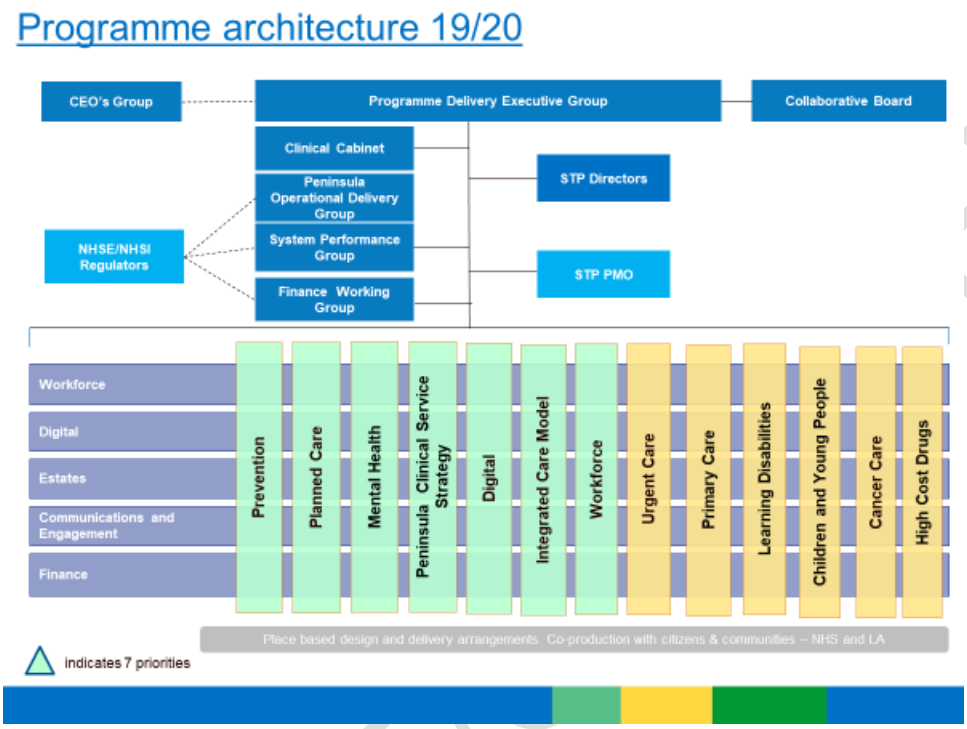
[4] https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf

Informal structures for organisations and agencies coming together at “place” level are in place and are understood in Devon as the 5 Local Care Partnerships (LCPs).

From the 1 July 2019, 31 PCNs came into being so creating the “neighbourhood” tier. 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 PCNs are primarily to offer a way of stabilising primary care and improve primary care access for the population.

Developing the Governance and Accountability Arrangements

It is the role of the ICS to set the governance and accountability arrangements across the system that supports each level to fulfil its function. At present there is an established structure:



The structure has served the system well to date, however, as we move toward becoming an ICS and taking on the all the functions required, it is no longer fit for purpose.

The Collaborative Board comprises a very broad range of partners and stakeholders that all have an interest in the health and care of the population. It has Officers, Non -Executives and elected Members on it together with partners from the independent and third sectors. There is a growing lack of clarity about its role. It does not have enough time or capacity to undertake a robust assurance role, it has no authority over financial or performance issues and the opportunity it affords for the development of system wide strategies to improve the whole population’s health is not fully exploited.

The Programme Delivery Executive Group (PDEG) is the collective senior leadership forum for the Statutory partners and others with a significant delivery role within the system. Currently it has a role reviewing the NHS system performance and financial delivery and a role in providing oversight to system programmes of work – workforce, digital, the integrated care model as example. As the only forum of its type across the system it also gives a collective view on items such as the Devon Long Term Plan (LTP) submission, the Winter Plan and other system wide planning documents. It is an Officer forum.

The Proposal

The overall structure, delivery architecture and governance of an ICS is currently not mandated, and each system is developing its own model. NHSE/I are currently talking with all the relevant stakeholders to consider whether there should be some national guidance and/or direction. This means it is possible that there may be some mandated national alignment about the nature and structure of an ICS and all associated governance in 2020. Early sight of that national discussion suggests it is unlikely that this will cut across the work done within Devon to date and therefore it is recommended that the system does not lose the momentum and engagement through a "pause" to wait for any national view.

The group, referred to in the introduction to this paper, agreed that some of the expected functions of an ICS would include:

- Setting strategic objectives and outcomes to improve the health and well-being of the Devon population (Population Health Management)
- Determining the allocation of resources to "places" (sub sections of the county based on a geographical footprint and recognised in county boundaries) that will be served by Local Care Partnerships (LCPs)
- Ensuring that health inequalities are addressed across Devon
- Seeking to influence the application of resources from areas outside health and social care that have a direct impact of the health and well-being of the population to maximise improvement opportunities (housing, employment, education etc.)
- Supporting the spread and adoption of best practice
- Assurance of delivery of the expected improvements in outcomes within the resource envelope and to agreed performance, quality and regulatory standards
- Oversight of large-scale strategic transformation projects
- Ensuring active and effective stakeholder engagement and public participation at system level
- Accountability back to the population of Devon

Early sight of the functions being considered at a national level, and as part of the engagement discussed, suggests that the Devon system is safe to assume the functions as described are in accordance with NHSE/I current thinking that is:

1) Planning and co-ordinating system transformation at system, place and neighbourhood
2) Management of system performance including health outcomes, quality of care, operational and financial performance

To discharge these functions, it was considered that there would need to be a dedicated ICS Board that conducted the business of the ICS.

It is felt that it is important that this Board does not replicate the organisational Boards of the Health and Social care providers as its role was not to provide or deliver 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) that are clearly about delivery of integrated care.

DRAFT/CONFIDENTIAL

Proposed ICS Board Structure

The structure put forward for considerations is:

- An Independent Chair
- 3 Leaders of the 3 Local Authorities
- 5 system Non-Executive Directors with alignment to “place”
- 1 Chief Executive
- 1 Population Health Director (DPH) – that would link with the Chairs of the Health and Well Being Boards and the other 2 DsPH
- 1 Finance Director
- 1 Strategic Commissioner
- 3 Clinical Representatives

It was agreed that the non-executive and elected membership of the Board, should mirror the current voting superiority of NHS organisations. This would mean at least one more non-executive member than executive.

There was discussion regarding the position of the Leaders of the Council that are elected members (so not Officers) but Executive. It was considered this was the appropriate seniority.

The role of Independent Chair would be appointed through the NHS line and hosted by the Clinical Commissioning Group (CCG) with involvement of the Collaborative Board. Latest thinking from NHSE/I is that the role cannot be appointed by the Collaborative Board (or equivalent) as the Collaborative Board is not a Statutory entity as Foundation Trust Governors are, as example. The Chair would also be the Chair of the Collaborative Board.

System non-executives should be found through an open recruitment process against clearly defined skill sets and experience. This should include education and the voluntary sector. It is preferable that they also can link “place” and can be “hosted” by the CCG as the ICS is not a legal entity. It may be that existing NHS NEDs from the Devon NHS organisations wish to apply for these roles and in that case, they can remain “hosted” by their NHS organisation but must relinquish all activity for that organisation. This option was felt important as it allows for the opportunity of existing, experienced Devon NEDs to apply for the roles if they choose and improve the ability for the Board to work at pace.

Clinical representation must demonstrate experience across primary, secondary, community, mental health and social care within the 3 Board members. This will be tested through open recruitment and interview process.

It was agreed that there would be an Executive ICS group comprising the Chief Executives and Officers of the statutory partners that would work to the ICS Board in a similar arrangement to the current Programme Delivery Executive Group.

DRAFT/CONFIDENTIAL

Collaborative Board and LCPs

The role and function of the ICS Board, together with its membership has an impact on the system governance arrangements at Collaborative Board and LCP levels.

Developing an ICS is a collective endeavour and it is for the Collaborative Board to consider its function should the proposal be accepted. The collective group working on the proposal thought it would be helpful for the Collaborative Board to consider the following as part of its function:

- Engagement with, involvement in and support for system wide strategies
- A role in the accountability arrangements for the Independent Chair[5]
- A role in agreeing the performance metrics by which the ICS measures its success

The Collaborative Board meet in early December to consider the proposal for the shadow ICS Board and its own role within the governance of the ICS.

LCPs currently exist in all areas; however, they are largely disconnected from the STP. Given the expectation of the ICS and the functions to be delivered at LCP level this will need to be resolved.

Relationship to NHSE/I

NHSE/I act as the Regulator for NHS organisations and currently discharge this function through a performance management framework with individual NHS organisations. NHSE/I is working through how it changes its operating model to fit with an assurance function at system level whilst still having Regulatory powers at single organisation level. The mechanisms for oversight and governance are in the very early stages and it is inevitable that for the next 12 months there will be some ambiguity as the national governance model evolves.

System Working and Assurance

To be effective the ICS needs to have a common purpose and an agreed way of working. Alongside the paper at Annexe B & C are the proposed refreshed and revised Memorandum of Understanding (MoU) to bind the Statutory Partners and a System Assurance Framework to enable all parts of the system governance arrangements to function effectively. You are asked as part of the Governance arrangements to consider both documents and signal your organisation's willingness to support both and be a signatory on the MoU.

Philippa Slinger
Lead Chief Executive
Devon STP

29/11/19

DRAFT/CONFIDENTIAL

[5] NHSE/I set out that each ICS should have an Independent Chair, likely to be accountable to the region