NHS
Bury
Clinical Commissioning Group

Meeting: Governing Body

Meeting Date	23 January 2019	**Action**	Receive
Item No.	07	**Confidential**	No
Title	Governance in an Integrated Health and Care System		
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Executive Summary

In 2016, the CCG and Council jointly signaled a direction of travel to develop an integrated approach to health and care commissioning, setting out the advantages and benefits that joined-up working will have for our patients and residents.

More recently in October 2018, an Accountable Officer of the CCG, who is also the Chief Executive for the Council, was appointed to cement at the most senior level the joint working across both organisations.

In addition, and to realise the ambition, the CCG and Council have identified key priorities:

- Commissioning and decommissioning strategy;
- Joint financial plan and reporting;
- Pooled & aligned budgets & management arrangements;
- Performance and outcomes framework;
- Risk and quality assurance framework; and
- OCO shadow / partnership agreement and governance including developing and agreeing a model for integrated commissioning.

This paper provides some background and context to start a discussion, specifically in relation to the last bullet point, on the options for more streamlined governance starting with the Governing Body, its Sub-Committees and the Primary Care Commissioning Committee.

Recommendations

It is recommended that the Governing Body:

- Reflect on the content of this paper; and
- Support arrangement of a workshop at the next meeting of the Governing Body to develop the thinking further with a view then to a joint discussion with Council colleagues.

Links to CCG Strategic Objectives

To encourage people so that they want to, and do, take responsibility for their own health and well-being.	☐
To drive and support system wide transformation.	☐
To commission joined-up health and social care for people in Bury through a Single Commissioning Framework.	☐
To achieve financial sustainability for the Bury health and social care economy.	☐
To support the Locality Care Alliance to deliver high quality services in line with commissioner intentions.	☐
To be a high-performing, well-run and respected organisation with an empowered workforce	☒
Does this report seek to address any of the risks included on the Governing Body Assurance Framework? If yes, state which risk below:	
GBAF – n/a	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☐
Have any departments/organisations that will be affected been consulted?	Yes	☐	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☐
Are there any financial Implications?	Yes	☐	No	☐	N/A	☐
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☐
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☐
Are the risks on the CCG's risk register?	Yes	☐	No	☐	N/A	☐

Governance in an integrated Health and Care System

1. Introduction

1.1 This paper is to provide some background and context to support a discussion on the options for more streamlined governance starting with the Governing Body, its Sub-Committees and the Primary Care Commissioning Committee.

2. Background

2.1 In 2016, the CCG and Council jointly signaled a direction of travel to develop an integrated approach to health and care commissioning, setting out the advantages and benefits that joined-up working will have for our patients and residents.

2.2 More recently in October 2018, an Accountable Officer of the CCG, who is also the Chief Executive for the Council, was appointed to cement at the most senior level the joint working across both organisations.

2.3 In addition, and to realise the ambition, the CCG and Council have identified key priorities:

- Commissioning and decommissioning strategy;
- Joint financial plan and reporting;
- Pooled & aligned budgets & management arrangements;
- Performance and outcomes framework;
- Risk and quality assurance framework; and
- OCO shadow / partnership agreement and governance including developing and agreeing a model for integrated commissioning.

2.4 A discussion is now required on what our operating model should look like in a local integrated system and the governance needed to enable timely and well-informed decision making.

3 Governance in an integrated Health and Care System

3.1 The Health and Social Care Act 2006 (as amended) and the National Health Service (Clinical Commissioning Groups) Regulations 2012 set out the requirements in respect to the Governing Body, its role, functions and constitution.

3.2 In addition, under the arrangements for Delegated Commissioning of Primary Care from NHS England, the CCG is also required to have a standalone Primary Care Commissioning Committee. It is important that future governance arrangements for this Committee are also considered, however it should be noted that because the functions being exercised by the Primary Care Commissioning Committee are actually NHS England functions, exercised on behalf of NHS England by the CCG, these functions cannot be further delegated. This means that they cannot be delegated to a Joint Committee.

- **Governing Body – its role and function**

3.3 The main function of the governing body, which is accountable to the Clinical Commissioning Group, is to ensure that the CCG has made appropriate arrangements for ensuring that it complies with:

- its obligations under section 14Q (duty to exercise its functions effectively, efficiently and economically; and
- such generally accepted principles of good governance as are relevant to it.

3.4 The Governing Body also has:

- the function of determining the remuneration, fees and allowances payable to the employees of the clinical commissioning group or to other persons providing services to it;
- the function of determining the allowances payable under a pension scheme established under paragraph 11(4) of Schedule 1A; and
- such other functions connected with the exercise of its main function as may be specified in the group's constitution or by regulations.

3.5 The Governing Body may have additional functions conferred upon it, as follows, however it is important to note that each additional function must be detailed within the CCG Constitution and cross referenced with the Scheme of Reservation and Delegation (SoRD) accordingly:

- where a clinical commissioning group specifies in its constitution that it wants its Governing Body to undertake additional functions connected with the two main functions (as permitted by section 14L(3)(c) of the 2006 Act)
- where a clinical commissioning group specifies in its constitution that it wants to delegate to its Governing Body functions of the CCG (as permitted by paragraph 3(3)(b) of Schedule 1A to the 2006 Act)

3.6 The full functions as currently detailed within the CCG Constitution, including those outlined above are included at Appendix A.

- **Governing Body – Committees and Sub-Committees**

3.7 The Governing Body is required by statute to have an Audit Committee and a Remuneration Committee, both of which should be, and are in respect to the CCG's arrangements, chaired by a Lay Member. The CCG may establish other committees as required.

3.8 The CCG currently has the following committees in addition to those required by Statute:

- Clinical Cabinet;
- Patient Cabinet;
- Finance, Contracting and Procurement Committee; and
- Quality and Performance Committee.

3.9 It should be noted that the Membership supported changes to the Governance Structure, including the sub-committees of the Governing Body, to those detailed above, in 2016 following an internal review.

- **Governing Body - Composition**

3.10 The 2012 Regulations set out the required statutory roles required to convene the Governing Body, as follows:

- the CCG's Accountable Officer;
- an employee of the CCG who has a professional qualification in accountancy and the expertise or experience to lead the financial management of the CCG

(who is to be known as the Chief Finance Officer);
- a registered nurse (but not one who falls within the definition provided in Regulation 12(1));
- an individual who is a secondary care specialist (but not one who falls within the definition provided in Regulation 12(1));
- a lay person qualified for membership who must have qualifications, expertise or experience such as to enable the person to express informed views about financial management and audit matters; and
- another lay person qualified for membership who has knowledge about the area specified in the CCG's constitution such as to enable the person to express informed views about the discharge of the CCG's functions.

3.11 In addition to these statutory requirements, NHS England strongly recommends that CCGs appoint a third lay member, as set out in its statutory guidance Managing Conflicts of Interest: Revised Statutory Guidance for CCGs 2017. Bury CCG has 3 lay members.

3.12 CCGs may choose to have additional members on the Governing Body. Where a CCG choses to add further roles to its Governing Body, a short description for each category of member must be included within the CCG's constitution in accordance with section 14L(4)(c) of the 2006 Act. Additionally, the CCG must ensure that the categories (and the individuals they appoint to the roles) are not disqualified by Schedule 5 of the NHS Clinical Commissioning Groups Regulations 2012.

3.13 The following table details the current composition of the Governing Body:

	Statute	Constitution
CCG Chair (the constitution states that from the Chair and Chief Operating Officer roles, one will be the Accountable Officer and one will be a practising GP and from a Bury member practice)		✓
Chief Operating Officer (the constitution states that from the Chair and Chief Operating Officer roles, one will be the Accountable Officer and one will be a practising GP and from a Bury member practice)		AO included in own right
Six Clinical Representatives of member practices, the majority of which will be GPs from member Practices		✓
Lay Member – Audit, Remuneration and Conflicts of Interest	✓	
Lay Member – Patient and Public Involvement	✓	
Lay Member – Quality and Performance (changed from risk)		✓
Registered Nurse	✓	
Secondary Care Specialist Doctor	✓	
Accountable Officer	✓	
Chief Finance Officer	✓	
Executive Nurse		✓
Director of Commissioning		✓
Public Health Member		✓*

* it should be noted that whilst the Constitution references this role as a voting member, this has been amended in practice to ensure compliance with the regulations and the Director

of Public Health is an attendee of the Governing Body to inform and contribute to Governing Body discussions.

3.14 In addition, the CCG can invite specified people to work with the Governing Body but without them having a vote. This invite, within the CCG's Constitution is extended to:

- Bury Local Authority Officer

3.15 The Governing Body is required to have a chair and a deputy chair. Where the chair of the Governing Body is a health care professional within the meaning of section 14N of the 2006 Act, as is the case for Bury CCG, all members of the Governing Body other than lay persons are disqualified from being deputy chair. The Lay Member with responsibility for Quality and Performance is the Deputy Chair.

- **Governing Body – Meeting in Public**

3.16 The Act requires the CCG to make appropriate provision for meetings of the Governing Body to be open to the public, except where it is considered that it would not be in the public interest to permit members of the public to attend a meeting or part of a meeting.

3.17 The CCG's Standing Orders currently detail that the Governing Body will meet no less than 6 times per year and no less than 3 months apart.

- **CCG Constitution – Making Changes**

3.18 Under section 14E of the 2006 Act, a CCG may apply to NHS England to vary its constitution (including varying its area or its list of members). If NHS England grants the application, the variation to the constitution will come into effect.

3.19 As currently detailed within the SoRD, the Clinical Commissioning Group (Membership) have reserved authority for approval of any changes to the CCG Constitution to themselves, and therefore this is the primary route that must be followed prior to submission to NHS England.

3.20 Recently NHS England have published a new model constitution and supporting guidance, and whilst there is no statutory requirement to adopt this, CCGs are encouraged to undertake a review to ensure their current approved constitution is up to date.

3.21 Recognising that the process of approving all changes to the Constitution can be an onerous task and often introduces significant delays, the new guidance suggests that CCGs consider adopting an arrangement which affords greater flexibility for changes that are not material. Such a change would need to be agreed by the Membership.

3.22 Applications to vary the CCG Constitution can be considered throughout the year, unless this includes changes to the CCG's boundary or list of Members which must be submitted before 30 June.

3.23 It should be noted that all proposed changes to a CCG Constitution, once approved by Members, has to be submitted to NHS England and this process can take a number of months.

- **Shadow / Interim Arrangements**

3.24 Clause 6.4 of the CCG's Constitution outlines that the Governing Body, on behalf of the CCG, may appoint such committees as it considers may be appropriate and delegate to them the exercise of any functions of the Group, subject to the SoRD. This includes joint committees with other CCGs or Local Authorities.

3.25 Pending any formal changes, an (informal) OCO Partnership Board has been established which reports to both the Governing Body and Council. No formal authority or duties have been delegated to this Board by the CCG.

3.26 The OCO Partnership Board comprises six nominations from the CCG and six nominations from the Local Authority. The CCG's nominations mirror its Governing Body composition with a mixture of clinicians, managers and lay members. The Local Authority's nominees are a mixture of Councillors and Managers.

3.27 The full composition is:

- the Clinical Chair of the CCG;
- one Lay Member of the CCG;
- one Clinical Director of the CCG;
- three CCG Executive Directors of the CCG from the following: the Chief Accountable Officer, Deputy Chief Officer/Director of Commissioning and Business Delivery, Chief Finance Officer and the Director of Quality;
- the Leader of the Council;
- the Deputy Leader of the Council (Cabinet Member for Health and Well Being);
- Chief Executive of the Council;
- the Executive Director for Communities and Well Being;
- the Executive Director for Children, Young People and Culture; and
- the Chief Finance Officer ("Section 151 officer").

3.28 In addition, the Council Monitoring Officer has a standing invitation to attend.

4 Recommendations

4.1 The Governing Body is required to:

- reflect on the content of this paper; and
- support arrangement of a workshop at the next meeting of the Governing Body to develop the thinking further with a view to a joint discussion with Council colleagues.

Appendix A: Governing Body responsibilities as outlined in the CCG Constitution

a) ensuring that the group has appropriate arrangements in place to exercise its functions *effectively, efficiently and economically* and in accordance with the groups *principles of good governance* (its main function);

b) determining the remuneration, fees and other allowances payable to employees or other persons providing services to the group and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act;

c) approving any functions of the group that are specified in regulations;

d) approving, publishing and monitoring the implementation of the Group's equality strategy for meeting the public sector equality duty;

e) promoting the involvement of all Members in the work of the Group in securing improvements in commissioning of care and services and developing the vision, values and culture of the Group in consultation with Members;

f) reviewing and monitoring the arrangements for working in partnership with the local authority to develop joint strategic needs assessments and joint health and well-being strategies and monitoring the delivery of the Group's responsibilities within such strategies;

g) approving and publishing the Group's public engagement strategy and annual public involvement report;

h) ensuring effective arrangements are in place to commission health services in such a way as promotes awareness of, and has regard to the NHS Constitution;

i) approving and monitoring the implementation of the Group's strategies and plans to secure continuous improvement in the safety and quality of services including safeguarding children and vulnerable adults utilising information available to help identify areas for improvement to ensure better health, better outcomes and better value for the residents of Bury;

j) assisting the NHS Commissioning Board in its duty to improve the quality of primary medical services by seeking to increase the capability, competence and capacity of primary care, and the proportion of health and social care provided by primary and community services;

k) ensuring the Group has effective plans in place to reduce inequalities across the borough;

l) promoting the involvement of patients, their carers and representatives in decisions about their healthcare;

m) ensuring effective systems are in place across its Member practices and commissioned providers to enable patients to make choices about their care;

n) ensuring the Group, in its decision making, obtains advice from a wide-range of professionals and representative organisations including LMC,LPC,LDC and LOC

o) engaging in a collaborative approach within the local health system including but not limited to:
    i) the Local Medical Committee;
    ii) other local representative committees;
    iii) Bury Metropolitan Borough Council;
    iv) Health Watch;
    v) local health & social care providers;
    vi) the voluntary sector
    vii) other clinicians and allied health professionals;

p) ensuring effective systems are in place to promote innovation;

q) ensuring effective systems are in place to promote research and the use of research;

r) ensuring effective systems are in place to promote education and training;

s) approving and monitoring plans to support and drive the integration of health and social care services where these improve quality or reduce inequalities.

t) ensuring the Group has in place effective arrangements to:

    i. ensure expenditure does not exceed the aggregate of its allotments for the financial year;
    ii. ensure its use of resources does not exceed the amount specified by the NHS Commissioning Board for the financial year;
    iii. and in respect of any directions from the NHS Commissioning Board in respect of specified types of resource in a financial year, to ensure the Group does not exceed any amount specified;

u) approving and publishing a process for and an explanation of how the Group spent any payment in respect of quality;

v) managing the corporate strategic risks of the Group including regularly reviewing the groups assurance framework;

w) approving the Group's organisational development plan including the principles by which it will procure commissioning support;

x) exercising any other functions of the Group which are not otherwise reserved or delegated.