Executive Summary


1.2 The report outlines the requirements for the new commissioning and delivery of Health and Care in Rochdale; namely an Integrated Commissioning function and a Local Care Organisation for all Adults Health and Care.

1.3 The report describes the progress towards a single management function for the Council and HMR CCG (Heywood, Middleton Rochdale Clinical commissioning Group) with the Chief Executive of the Council becoming the Chief Accountable Officer for HMR CCG within the next 12 months. The Joint Director of Commissioning will take on the DASS responsibilities.

Recommendation

2. That members:

2.1 Approve the revised Terms of Reference for the Integrated Commissioning Board (ICB) and the governance arrangements associated with this;

2.2 Approve the delegations to ICB;

2.3 Approve the new governance and decision making structures; and

2.4 Delegate minor amendments to the Governance arrangements to the Chief Executive of the Council in consultation with the Portfolio Holder for Health and Wellbeing, and the Leader of the Council and Chair of HMR CCG Governing Body.

Reason for Recommendation

3. To ensure that the Council and HMR CCG have a governance system and management structure in place, that is able to oversee the Financial Planning,
Strategic Development and Delivery of Health and Social Care for the Borough of Rochdale.

3.1 To ensure that the Council and HMR CCG are compliant with GM ‘Taking Charge’ 2015 and have effective Governance and Financial controls in place for the delivery of the Transformation Fund agreement.

**Key Points for Consideration**

4. During 2015/2016 a series of proposals were adopted by both HMR CCG and the Council to progress toward integrated commissioning, pooled budgets for adults and public health and more recently the joint appointment of a Director of Integrated commissioning.

4.1 The Integrated Commissioning Board was established and a shadow pooled budget explored during 2016/2017 with delegations for decision making in respect of commissioning relating to the s75 and the Better Care fund (£16.1m)

4.2 GM health and social care devolution progressed in 2016/2017 and through agreements at the HSC strategic partnership ‘Taking Charge’ was accepted by all organisations involved with Health and Care across GM. The implications of this were the engagement of the CCG and the council in the four themes for GM:

   i) Radical upgrade in population health  
   ii) Transformed community based care and support  
   iii) Standardising Acute Care  
   iv) Standardising Clinical Support and Back Office

4.3 The most significant impact of the GM proposals for the CCG and the Council were that the Transformation Bids from each Locality had to fully reflect the expectations at the GM level namely ‘Transformed community based care and support’. This meant ‘Out of hospital care’ that was fully developed to meet the health, care and wellbeing of the population of the borough out of hospital care that was able to achieve improved health and wellbeing outcomes with the resources available for the population. Hospital services recalibrated to provide the best quality for those needing acute health interventions only. The Locality Plan Transformation Bid submission also had to demonstrate full cost benefit analysis and be able to financially demonstrate that all the actions taken would over five years return all the partners involved in health and care to financial balance.

4.4 A further expectation from GM was that all the other themes i.e. cross cutting themes would be aligned and embedded where appropriate in the local health and care systems. Examples of these are mental health and cancer care.

4.5 The concept of single place based commissioning has been developing over the last twelve months with a focus on added value for the use of resources i.e. pooled budget or aligned monies and efficiency of staffing resources used to deliver shared commissioning programmes. In addition to the Joint Director of Integrated Commissioning there are further posts including mental health
4.6 The shadow year of the ICB provided an opportunity to look at commissioning of health and social care commissioning and therefore service developments across health and care. A greater understanding has been reached about how the pooled budget can operate and a review of this has been undertaken by health auditors which will assist in the joint agreements going forward. A range of services have been jointly commissioned using the BCF monies in conjunction with other funding streams which have significantly improved the offer to older people who become unwell and for people with long term conditions – intermediate tier services and integrated neighbourhood teams. These have gained national recognition and awards for the difference this has made to people’s lives. The Outcomes Based Commissioning Framework has been recognised as a real strength in the contracting of provider partnerships and approaches that are then able to innovate and operate much more flexibly to make improvements.

4.7 In late 2016 through to current date the driving focus of work across the Rochdale council and CCG has been the submission of the transformation bid and the work this has required across all departments in both organisations. The bid was submitted 31st March 2017. The bid is now being evaluated and officers are fully engaged in the assurance process to try to ensure we achieve the maximum amount in order to transform our service offer and achieve financial sustainability.

4.8 In order to submit the transformation bid there was an additional requirement that the Rochdale, Bury and Oldham (North East Sector) group had to demonstrate that there had been a review across the three plan submissions. The financial implications and activity changes and their impacts on the major health providers Pennine Acute Trust and Pennine Care had to be understood and agreed by both providers. Governance arrangements to oversee the programmes of work at Pennine Acute Trust and at Pennine Care (their clinical strategy design and implementation) had to be agreed across the six commissioners of CCGs. These are now agreed across North East Sector.

4.9 The Transformation Bid spans April 2017-2021 and the submission from the Rochdale locality described the formation of a Local Care Organisation that will be the provider of health and social care for Rochdale. A Local Care Organisation Development board has been established with the appointment of an experienced independent chair to support the partnership. The expectation is that a Provider Alliance is formed with a host provider. This alliance will be capable of delivering health, social care and well-being services for Rochdale. (Appendix 1). The formation of the provider partnership contractual arrangement has yet to be agreed this will be undertaken within the requirements of the CGG and the Council for full due diligence.

4.10 A Local Care organisation provider board has been developed chaired by the same chair to immediately commence on the delivery of the interventions for a number of the plans for the Transformation Bid. The timeline for delivery is from the current date to 2021. This Board is focussed on making service changes to reduce the attendances at hospital and strengthen services in the community.
The programme management and implementation of the transformation bid will be managed by the single commissioning directorate and will report through to the ICB.

The ICB terms of reference have been revised for consideration to reflect the requirements in the new health and care system (Appendix 2) and the legal, financial and performance expectations of both the CCG and the Council. This will be a new committee with an Independent Chair that will have delegated accountability for adult social care, Children’s and public health budgets in 2018 and the adult health commissioning budget in the CCG. This equates to a potential pooled budget of £342m (based upon 2017/18 budgets) plus the Transformation Bid.

The governance system of health and care commissioning and delivery has been reviewed in light of learning from the shadow year of the ICB and examples of integrated commissioning and delivery of health and care over the last two years. The proposed system builds on the strong relationships and effective partnership working across all elements of health and care commissioning and delivery (Appendix 3).

The proposed system will provide assurance in terms of outcomes, quality of care and financial management and sustainability.

The ICB will have full sight of all budgets across health, social care, public health, adults and children’s in order to assure effective commissioning across all these areas of business and services. The pooled budget will grow as children’s services move towards a Family services model through the next 2 years where it is an added benefit to do so.

There are a number of areas of service where the legal framework and legislation is clear that they cannot be included in a pooled budget i.e. surgery, core primary care contracts, schools.

It is important for the ICB in overseeing the commissioning for the whole health and care system that all of the above budgets are visible in strategic planning to ensure there is coherence in achieving improvements in outcomes for Rochdale people and service improvements.

GMHSCP requirements for the Transformation Bid monies were that Rochdale develop a single place based commissioning function, a full pooled budget for adults and public health as a minimum and a Local Care Organisation is formed contractually. Progress towards this and governance changes required have been outlined above.

With respect to a single commissioning function the CCG and Council will merge its structures into the Council and retain only one Chief Accountable Officer for health and care. The Joint Director of Commissioning will take on the statutory DASS role from September 2017 as a progression of the single Commissioning function.

The CCG will remain statutorily and all the legislative requirements will have to
be fulfilled including specifically clinical engagement and leadership in decisions about health and care delivery and design

4.15 **Alternatives Considered**
Governance models across Greater Manchester have been reviewed to progress the ICB. The ICB structure and terms of reference reflect these considerations.

### Costs and Budget Summary

5. The Integrated Fund for the delivery of Health and Social Care functions across the Borough of Rochdale will have a Pooled Fund, to which Governance and Financial Management is being requested to be delegated to the Integrated Commissioning Board. Within the Integrated Fund there will be aligned budgets to which Cabinet and CCG Governing Body will retain decision making powers, however spend and budgets of the aligned budgets will be reported to the Integrated Commissioning Board for information. This will allow influence of the spending decisions to ensure the delivery of the best possible outcomes with the Integrated Fund for the citizens of Rochdale.

5.1 The indicative value of the Integrated Fund is £393m, and £384m will form the pool Fund. However work is ongoing with relevant Directors and CCG Colleagues to better understand which budgets will be aligned / pooled.

The following tables details the indicative values of the Pooled Fund and aligned services:

Table 1

<table>
<thead>
<tr>
<th>Service area</th>
<th>Budget £M's</th>
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<tbody>
<tr>
<td>LA: Adult Social Care</td>
<td>51.970</td>
</tr>
<tr>
<td>LA: Children Services</td>
<td>35.325</td>
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<tr>
<td>LA: Public Health</td>
<td>13.158</td>
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<tr>
<td>CCG</td>
<td>241.491</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>341.944</strong></td>
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<tr>
<td>BCF</td>
<td>24.771</td>
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<tr>
<td>Transformation Fund</td>
<td>16.863</td>
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<td><strong>Total</strong></td>
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### Table 2

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<th>Aligned Services</th>
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<th>£m</th>
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<tr>
<td>Children Services</td>
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<td></td>
</tr>
<tr>
<td>Link4Life</td>
<td>2.546</td>
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<tr>
<td>Public Health</td>
<td>3.862</td>
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<tr>
<td><strong>Total Aligned</strong></td>
<td>9.124</td>
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### Risk and Policy Implications

6. Decisions regarding resource allocation for Health and Social Care will be taken jointly by the Council and HMR CCG through delegated decision making to the Integrated Commissioning Board.

Strategy and Policy development for Health and Care for Rochdale Borough will be approved through the Integrated commissioning Board.

A financial risk share agreement will be required to ensure full compliance with the requirements of the constitutions of both the Council and HMR CCG. This will be subject to a further report to Cabinet.

### Consultation

7. Locality Plan consultation and engagement has taken place through 2015/16 and 2017 with the public and staff across Health and Care Organisations in the Rochdale Borough.

### Background Papers

<table>
<thead>
<tr>
<th>Background Papers</th>
<th>Place of Inspection</th>
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<tr>
<td>8. Appendices 1-3</td>
<td></td>
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<td>GM ‘Taking Charge’ 2015</td>
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### For Further Information Contact:

<table>
<thead>
<tr>
<th>Sally McIvor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Director of Integrated Commissioning</td>
</tr>
<tr>
<td><a href="mailto:sally.mcivor@rochdale.gov.uk">sally.mcivor@rochdale.gov.uk</a></td>
</tr>
<tr>
<td>01706 924079</td>
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APPENDIX 1:

TERMS OF REFERENCE

ROCHDALE
LOCAL CARE ORGANISATION
DEVELOPMENT BOARD

VERSION 2.0

VERSION CONTROL

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<th>Purpose/Change</th>
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<td>24 February 17</td>
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<td>Initial document</td>
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<td>27 February 17</td>
<td>M Court</td>
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<td></td>
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<td>9 March</td>
<td>M Court</td>
<td>To meet LCO Programme Board agreement</td>
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RECORD OF STAKEHOLDER ENGAGEMENT

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<th>Outcome/Feedback</th>
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<td>1</td>
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<td>Minor amendments</td>
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Introduction

This document sets out the arrangements for how commissioners and providers will work together in true partnership to lead the creation of the Local Care Organisation (LCO), agree the overall strategic direction and priorities for the integration of health and care services for the population of Rochdale, be assured of progress and that key risks are being effectively managed.

The Programme Board is a board comprising very senior officers representing the Boards of BARDOC, GP Care Services Ltd, NHS Heywood, Middleton and Rochdale CCG (HMR CCG), North West Ambulance Service NHS Trust (NWAS), Pennine Acute NHS Trust (PAHT), Pennine Care NHS Foundation Trust (PCFT), Rochdale Borough Council (RBC), Rochdale Health Alliance (RHA), and the Council for the Voluntary Sector in Rochdale (CVSR).

The Programme Board will operate with the principles of partnership working and collective decision-making, whilst recognising that commissioning decisions will ultimately be taken by HMR CCG and RBC, through the joint commissioning arrangements.

The Programme Board will ensure the effective engagement of stakeholders. It will maintain an overview of the implementation of the system redesign at a partnership level, enabling partners to consider any issues that arise for resolution.

It is recognised that on occasion, difficult decisions may be required to benefit the population of Rochdale. The Programme Board will have decision-making powers in its own right as a result of its members having delegated decision-making authority from their respective organisations.

It will take decisions relating to the use of transformation resources allocated to the programme. Where consensus cannot be reached on such matters, decisions will be referred back to individual organisations.
Through its decision making processes, the Programme Board will adhere to the constitutions of its member’s organisations.

As required, the Programme Board will establish sub committees and/or task-and-finish groups and will seek assurances on progress via the receipt of regular reports.

These Terms of Reference shall be approved by the Board of Directors of the member organisations, including HMR CCG’s Governing Body and RBC’s Cabinet (both in consultation with the joint Executive Teams), and they will remain valid until such time as there is a need to implement revised arrangements.

2. Core Principles and Responsibilities

The work of the LCO Programme Board will be driven by the following core principles:

- Decisions will be based on achieving better outcomes and experience for the whole population who require Health and Care Services, rather than that of any one organisation;
- Service transformation will deliver an effective and efficient use of resources (within the statutory requirement of members duties) whilst assuring safe and effective standards of service;
- New care models will be co-designed by health and social care commissioners in partnership with providers, citizens and communities;
- Services will be evidence-based and of the best quality, encompassing safety, effectiveness and experience that is obtainable within the available financial envelope;
- Rochdale residents will be given more choice and control of services, supporting self-care and independence;
- Clinical and democratic accountability will be implicit within all decisions;
- Respect for professional areas of knowledge and expertise;
- Collective management of risks and benefits; and
- Each organisation remains sovereign: whilst responsibilities can be delegated, accountability for those responsibilities cannot.

The LCO Programme Board has the responsibility to

- work towards shared goals and objectives;
- develop true partnership working amongst members;
- lead the creation of the LCO organisational form;
- determine and agree the governance arrangements required to deliver the out of hospital transformation programme (Rochdale Locality Plan), including the review of existing governance arrangements to ensure an effective whole system approach;
- review and agree the proposed vision and phasing for the development of the out of hospital programme;
- review and set the priorities for the programmes of work to deliver the out of hospital transformation programme;
- ensure the effective design, implementation and programme management of the transformation programmes and delivery of the agreed model of integrated care, including the review of existing initiatives to align complimentary work streams and consolidate programmes/projects;
- be assured of progress towards the achievement of the prioritised programmes of work;
- review and agree the submission(s) to GM Partnership regarding the requests for transformational funding to enable the delivery of the out of hospital transformation programme;
- to manage the allocated budget, constantly seek means to reduce costs whilst maintaining quality standards, and approve proposals for the use of transformation funding;
- ensure that all aspects of financial governance are followed;
- advocate engagement of public, service users and patients;
- ensure that all aspects of best practice, both nationally and internationally are duly considered and where appropriate applied;
- establish arrangements to enable the development of new models of care, including the maximisation of available resource across organisational boundaries;
- develop a robust evaluation framework to ensure progress can be measured;
- advise on proposed changes to existing payment mechanisms and contractual arrangements where necessary;
- ensure that appropriate risk management and escalation processes are correctly adhered to.

The LCO Programme Board will discharge its responsibilities through agreed governance arrangements eg LCO Provider Board, with the support of programme work streams and task-and-finish groups as deemed necessary.

3. Membership, Attendance and Quorum

Membership

The LCO Programme Board will comprise the following core members

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Role</th>
</tr>
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<tbody>
<tr>
<td>BARDOC</td>
<td>Chief Executive</td>
</tr>
</tbody>
</table>
Organisations and individuals will be co-opted onto the LCO Programme Board as necessary on an ad-hoc basis to inform discussions, deliver a report to it and/or answer questions including matters relating workforce, IMT, estates and communications/engagement.

The Board will be chaired by an Independent Chair. In the absence of the independent chair the Board will be co-chaired by two Vice Chairs, one representing GPs the other either from PAHT or PCFT, as selected by the members of the LCO Programme Board.

Agendas will be jointly agreed in terms of content and based on forward planning. They will be issued within 5 days of the meeting.

The LCO Programme Board will formally record its deliberations within relevant minutes/action notes that will be issued within 5 working days of the meeting. This function will be undertaken by the designated administrative support, alongside the management of paperwork and version control.

Administration and programme management support will be provided through the application to GM Partnership for transformational funding. The Programme Director will attend the Board meetings.

Attendance

It is important that partner organisations commit to ensure that their nominated representatives attend the LCO Programme Board. Where this is not possible appropriate deputies are required to attend. Deputies must be able to contribute and make decisions on behalf of the individual / organisation they are representing.

Should attendance not be as expected this will be discussed by the Independent Chair with the relevant organisation to seek recommitment to the programme.

Quorum, Decision Making and Voting

The LCO Programme Board will be quorate providing there are at least one member from a commissioner and one from a provider, and also that at least half of the membership is in attendance.
The LCO Programme Board is required to achieve a consensus for all decisions. Given the nature of the programme, securing the support of all partners will be critical to the success of the transformational programme. In those circumstances where consensus cannot be reached and a decision must be taken, the issue will be referred back to the sovereign bodies of each organisation for a decision. Before choosing to put the issue to a vote, the LCO Programme Board may ask for further work to be undertaken on the issue to explore, clarify, mitigate or minimise any concerns. The LCO Programme Board may ask for specific individuals who may or may not be part of the Board to discuss the issue further to try to find a suitable resolution. The issue would then be brought back to a future meeting.

The LCO Programme Board has decision making authority to approve significant service variations or developments within the scope of the out of hospital transformation programme and the associated funding envelope. This decision making ability is based on the partner organisations providing delegated decision making to their representatives.

In addition, the LCO Programme Board has responsibility for the approval of transformation funding. Where there is disagreement amongst the partners regarding the use of such funding this will be resolved through the process described above.

Responsibilities and Behaviour

Members of the LCO Programme Board 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.

Members will behave in a manner consistent the Nolan Principles, recognising that the success of the work programme will depend upon relationships and an environment of integrity, trust, collaboration and innovation.

Each member of the LCO Programme Board has an equal voice.

4. Patient, Public and Service User Involvement

The LCO Programme Board will ensure that the development and implementation of service transformation and integrated care activities will include advice from appropriate service users, patient and public involvement, as well as from clinicians and other experts.

5. Conflicts of Interest/ Codes of Conduct

Members will be aware of what may constitute a conflict of interest, will ensure that conflicts of interest are formally disclosed and will ensure they are subsequently managed in adherence with the organisations’ respective conflict of interest policies. In addition, appropriate codes of conduct will be followed at all times alongside adherence to the Nolan
Principles and compliance with any statutory bar on participation and/or voting in particular circumstances.

Depending upon the topic under discussion and the nature of the conflict of interest, the member may be

- allowed to remain in the meeting and contribute to the discussion;
- allowed to remain in the meeting and contribute to the discussion but leave the meeting at the point of decision; or
- asked to leave the meeting for the duration of the item under consideration.

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.

6. Frequency of Meetings

Meetings of the LCO Programme Board will ordinarily be scheduled on a monthly basis.

The frequency of meetings will be reviewed at six and twelve months and in any case will take place bi-monthly as a minimum. The Chair may call extraordinary meeting with a minimum of five working days’ notice.
7. Reporting

The LCO Programme Board will be accountable to the Integrated Commissioning Board.

Shadow Phase

- Rochdale’s TF BID Delivery Plan – Managed CCG/RBC– shared responsibilities (CCG/RBC and LCO Development Board)
- TF BID – PMO hosted by CCG/RBC
- PMO and Integrated Teams of Clinical leads, Commissioners, Providers managing the delivery of TF interventions
- Programme delivery for some TF elements overseen by LCO Programme Development Board
- LCO Development Board live

Final State

- Commissioning Priorities set by Integrated Commissioning Unit
- TF bid delivery fully delegated to LCO Provider Board
- PMO and Integrated Teams of Clinical leads, Commissioners, Providers managing the delivery of TF interventions
8. Policy and Best Practice

The LCO Programme Board will apply best practice in its deliberations and in making any recommendations. It will conduct its business in accordance with national guidance and relevant codes of conduct and good governance practice.

9. Review of Terms of Reference

These Terms of Reference will be formally reviewed by the LCO Programme Board after 12 months and may be amended by mutual agreement between all parties at any time to reflect changes in circumstances which may arise.

Terms of Reference Agreed on: .............................................

Review Date: ...............................................................

Mike Court
LCO Programme Manager March 2017
APPENDIX 2:

INTEGRATED COMMISSIONING BOARD

TERMS OF REFERENCE

1. To commission high quality health, social care and related services for the people of the Borough of Rochdale in order to meet assessed population, community and individual need, within the financial resources over which the Board has control.

2. To agree the Health, Social care and Well-being commissioning strategies and commissioning outcomes for Rochdale Borough Council (RBC) and NHS Heywood, Middleton and Rochdale Clinical Commissioning Group (HMRCCG) in accordance with the agreed delegations from RBC and HMRCCG.

3. To manage all the pooled budgets established under section 75 of the National Health Service Act 2006.

4. To agree the allocation of resources for the delivery of the integrated commissioning strategies through the use of pooled or aligned budgets from HMRCCG and RBC. This will ensure that the wellbeing, social care and health-related functions of RBC and the prescribed functions of HMR CCG in commissioning health-related services are undertaken.

5. To approve the associated strategic plans and work programmes prepared by the integrated commissioning programme leads

6. To approve integrated workforce development strategies and plans and associated resource allocations.

STATUTORY AND PROCEDURAL BASIS

The Integrated Commissioning Board has been established by NHS Heywood, Middleton and Rochdale Clinical Commissioning Group (HMR CCG) and Rochdale Borough Council (RBC) pursuant to the the NHS Bodies and Local Authorities Partnership Regulations 2000 as amended, and derives its authority and decision-making powers from these two organisations.

The Integrated Commissioning Board is established as joint committee under the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (as amended) whereby prescribed NHS bodies and local authorities may form such a joint committee to take responsibility for the management of partnership arrangements established in accordance with that Order.

The Local Authorities (Executive and Alternative Arrangements) (Modification of Enactments and Other Provisions) (England) Order 2001 provide that where a local authority operates
executive arrangements, the terms “executive” and “executive arrangements” have the same meaning as in Part II of the Local Government Act 2000.

ACCOUNTABILITY

1. The Integrated Commissioning Board will report to the Health and Wellbeing Board on the achievement of outcomes for commissioned services in meeting the agreed objectives. The Health and Wellbeing Board shall report concerns that cannot be resolved with the Integrated Commissioning Board to RBC and the HMRCCG.

2. The Integrated Commissioning Board will report to RBC and HMRCCG on the performance of the commissioning strategy and implementation and on the effective use of resources.

Members of the Integrated Commissioning Board who have the delegated accountability on behalf of RBC and HMRCCG to manage the functions of the Board shall be responsible for reporting to their respective bodies any concerns with regard to the functioning of the Board and the capacity of the Board in fulfilling their constitutional or statutory functions.

INTEGRATED COMMISSIONING BOARD WORKING ARRANGEMENTS

In pursuance of the terms of reference, the Integrated Commissioning Board shall:

1. Assure the HWBB on the delivery of commissioning for outcomes identified in the Joint Strategic Needs Assessment (JSNA) and specifically those identified as priority outcomes.

2. Oversee the development and establishment of integrated commissioning arrangements in the Borough, ensuring that the requirements of both HMRCCG and RBC are met, that they are based on best practice, and strategic alignment to the intent of the Greater Manchester Devolution Agreement, and specifically the Greater Manchester Health and Social Care Partnership, is maintained.

3. Govern the arrangements for integrated commissioning providing assurance to HMRCCG and RBC that their statutory responsibilities are being met, their strategic objectives are being addressed and that their combined resources are being used to best effect.

4. Govern the arrangements with strong clinical assurance and democratic accountability.

5. Be accountable for the achievement of the agreed commissioning strategies and plans on behalf of HMRCCG and RBC.

6. Ensure that the integrated commissioning strategies describe how the outcomes and objectives set out in the section 75 Agreements and aligned budget arrangements and the high-level strategic goals and outcomes of HMR CCG and RBC are to be achieved.

7. Be accountable for the commissioning of a Local Care Organisation (LCO) and for the assurance of the effectiveness of the LCO to meet the health, care and wellbeing outcomes for Rochdale.
8. Commit the resources within the pooled fund to achieve the objectives of the integrated commissioning strategies, within the level of delegated resources assigned to it.

9. Be responsible for developing a joint financial plan to underpin the overall commissioning strategy and providing direction in relation to investments and savings to be made by both partners.

10. Undertake an annual work-plan within the agreed budget to implement the integrated commissioning strategies. The work-plan will include the priorities for each operational commissioning programme for that year.

11. Set the standards for, and to monitor and review the outcomes and performance of commissioned services in line with the integrated commissioning strategy and work-plan, identifying areas for improvement and areas of good practice, taking action where outcomes and performance fall short of requirements.

12. Ensure the engagement of stakeholder groups, including users, patients and carers, providers and community organisations, in the commissioning cycle including where appropriate the co-design of commissioned services, the formulation of the integrated commissioning strategy and the annual work-plan.

13. Hold the Integrated Commissioning Directorate and the individual commissioning teams of the Partners to account for the performance and delivery of commissioning programmes as required by the agreed commissioning plan/strategy, the annual work-plan, and the section 75 Agreements.

14. Identify, record, mitigate and manage all risks associated with integrated commissioning, including the maintenance of a risk register which shall be included on the corporate risk registers of both HMRCCG and RBC.

15. Review regular performance and financial monitoring reports and ensure, if required, appropriate actions are taken to ensure annual delivery of expected performance targets and approved schemes within permitted budget for the financial year.

MEETINGS OF THE INTEGRATED COMMISSIONING BOARD

Formal public meetings of the Integrated Commissioning Board shall be held on a quarterly basis, with further meetings convened as required with the agreement of the Chair and Vice Chair. If the business to be considered involves confidential or exempt business, the Board can resolve to exclude the public during consideration of that business.

Members of the Board shall meet on an informal basis on further occasions to consider matters such as policy and strategy development, operational issues arising etc in order to formulate recommendations, where appropriate, for formal consideration and determination by the Board.
1. Membership

The voting membership of the Integrated Commissioning Board shall comprise an Independent Chair and membership drawn from the HMRCCG and RBC.

*Independent Chair*

An Independent Chair of the Board shall be appointed by the partners. The Independent Chair shall vote only to determine a matter in the event of an equality of votes.

A Vice Chair of the Board shall be appointed on a rotating annual basis between a HMRCCG member and an RBC member to chair meetings of the Board in the absence of the Chair. The Vice-Chair shall not have a second or casting vote.

The Partners have determined their voting memberships of the Board as follows –

**HMRCCG**

- One GP member
- Clinical Chair
- Chief Accountable Officer or nominee
- One Lay Member

**RBC**

- Cabinet member with responsibility for Adult Services
- Cabinet member with responsibility for Children’s Services
- Cabinet member with responsibility for Health and Wellbeing
- Cabinet member with responsibility for Finance

A nominated substitute is permitted to attend and vote in the absence of a Board member provided that notification of the substitution arrangement is given to RBC Governance Services by noon on the working day prior to the meeting and the nominated substitute is eligible to serve.

The voting membership shall be supported by the following attending Advisors –

- The Joint Director for Integrated Commissioning

**HMRCCG**

- Chief Finance Officer
- Director with responsibility for Primary Care, Quality and Support Services and Exec Nurses
- Chair of the Clinical and Professional Advisory Board
- One GP
2. Quorum

The quorum shall be three voting members from each partner organisation.

3. Voting

The Board shall seek to determine matters by consensus. If there is no dissent, decisions will be taken by the affirmation of the meeting.

If consensus cannot be achieved and in the event of a vote, each voting member from the partner organisations shall have one vote and a decision reached by simple majority. In the event of an equality of votes, the Independent Chair shall exercise a casting vote.

4. Conduct and Declarations of Interest

Members of the Integrated Commissioning Board shall comply with the requirements of the Codes and Protocols of their respective organisations.

With regard to the business being conducted at meetings of the Board, Members of Rochdale Council shall have regard to the Council’s Code of Conduct for Councillors and Voting Co-opted Members at Part 5A to the RBC Constitution and shall declare such interests are required under that Code and shall, where required, withdraw from the meeting.

With regard to the business being conducted at meetings of the Board, Members of HMRCGG shall have regard to Part 8 “Standards of Business Conduct and Managing Conflicts of Interest” of the HMR CCG Constitution and shall declare such interests as are required under that Part and shall, where required, withdraw from the meeting.

An up to date register of members’ interest will be retained. Members will be expected to declare any conflicts of interest at all meetings and the Chair will determine how any conflict will be handled in line with CCG policy and guidelines.

With regard to the business being conducted at meetings of the Board, the Independent chair shall comply with the Constitutional requirements of both RBC and HMRCGG and
shall declare such interests as are required of either or both partner’s process and shall, where required, withdraw from the meeting.

5. Meetings Procedure Rules

Formal meetings shall be convened and conducted in accordance with the provisions of the Procedure Rules at Part 4 of the RBC Constitution, particularly the Procedure Rules that provide the statutory basis for the conduct of meetings and business, and with the Standing Orders at Appendix C to the HMRCCG Constitution.

Where the statutory or procedural requirements for the conduct of meetings differ between partners, the particular option that addresses the statutory or procedural requirements of each partner, or which accords greater public access, shall apply.

The following provisions shall apply to the formal meetings of the Integrated Commissioning Board:

- Agenda and reports will be published and made available at least five clear working days prior to the day of a meeting.
- Papers and meetings will be open to the public except in circumstances where confidential and/or exempt matters are likely to be considered.
- Confidential information means information provided by a Government Department on terms which forbid its public disclosure or information which cannot be publicly disclosed by Court Order.
- Exempt information means:
  (i) Information relating to any individual
  (ii) Information which is likely to reveal the identity of an individual
  (iii) Information relating to the financial or business affairs of any particular person (including the authority holding that information)
  (iv) Information relating to any consultations or negotiations, or contemplated consultations or negotiations, in connection with any labour relations matter arising between the authority or a Minister of the Crown and employees of, or officer-holders under, the authority
  (v) Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings
  (vi) Information which, if disclosed to the public, would reveal that the authority proposes to give under any enactment a notice under or by virtue of which requirements are imposed on a person; or to make an order or direction under any enactment
  (vii) Information relating to any action taken or to be taken in connection with the prevention, investigation or prosecution of crime.

Information is exempt if and so long, as in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information. In all cases, before the public is excluded the meeting must be satisfied that, in all circumstances, the public interest in maintaining the exemption outweighs the public interest in disclosing the information.

- 28 days public notice of when Key Decisions, as defined at Part 4B of the RBC Constitution, are to be taken shall be given. In the event of less than 28 days
notice being provided, the General Exception or Special Urgency provisions of Part 4B of the RBC Constitution shall apply.

- 28 days public notice of the proposed consideration of business in private shall be given. In the event of less than 28 days notice being provided provisions to permit consideration on grounds of urgency as provided for in Part 4B of the Council's constitution shall apply.
- The Integrated Commissioning Board shall be subject to the Council's overview and scrutiny arrangements, including the eligibility of decisions for call-in and review, and the requirement to attend overview and scrutiny meetings.

6. Support

The Integrated Commissioning Board shall establish such operational sub-groups as it considers necessary to ensure the delivery of commissioning outcomes. Such sub-groups shall be kept under review to ensure their relevance going forward.

7. Review of Arrangements

The Integrated Commissioning Board shall review operational arrangements in March each year and, where necessary, make recommendations for amendments to the parent organisations.
Plans for Integrated Commissioning, Locality Plan and Greater Manchester Transformation Fund 2017/18
Proposed future new governance for Health and Care

- Cabinet
- Health Overview and Scrutiny Committee
- Health and Wellbeing Board
- ICB
- LCO Board
- CCG
- Professional and Clinical Advisory Board

Rochdale Borough Council
Place Based Commissioning

Health and Wellbeing Board

Cabinet

Professional and Clinical Advisory Board

Outcomes Commissioning

Start Well Live Well Age Well

ICB

ICD

Tactical Commissioning

LCO

CCG