Lancashire and
South Cumbria
Integrated Care Board

NHS Lancashire and South Cumbria Integrated Care Board

Governance Handbook

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1. Introduction

1.1. NHS England (NHSE) has set out the following as the four core purposes of Integrated Care Systems (ICSs):

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

1.2. The Integrated Care Board (ICB) will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

1.3. The arrangements described in the Lancashire and South Cumbria Integrated Care Board Constitution (the Constitution) describe how we organise ourselves together to provide the best health and care, ensuring that decisions are always taken in the interest of the patients and populations we serve. The constitution can be located on the ICB website (Lancashire and South Cumbria Integrated Care Board :: How we work (icb.nhs.uk))

1.4. The Constitution is underpinned by the duty that requires NHS bodies to consider the effects of their decisions on the health and wellbeing of the people of England, the quality of services and the sustainable and efficient use of resources.

1.5. The NHS Lancashire and South Cumbria Integrated Care Board will establish a mutual accountability with partners around the triple aims for systems:

- improving the health and wellbeing of the people of Lancashire and South Cumbria
- improving the quality of healthcare provided or arranged by both ourselves and other relevant bodies
- achieving sustainable and efficient use of resources by both ourselves and other relevant bodies

1.6. The Constitution is supported by this Lancashire and South Cumbria Integrated Care Board Governance Handbook (the ICB Governance Handbook) which provides further details on how governance arrangements in the ICB will operate by bringing together a number of governance documents, so it is easy for interested people to navigate.

2. Contents of the ICB Governance Handbook

2.1. The ICB Governance handbook includes or signposts to the following requirements described in the Constitution:

2.1.1. The Functions and Decisions Map

2.1.2. The Scheme of Reservation and Delegation (SoRD)

2.1.3. The Standing Financial Instructions (SFIs)

2.1.4. The Terms of Reference for committees of the board

2.1.5. Other Decision-making Groups

2.1.6. The Roles and Responsibilities of Board Members

2.1.7. Regular Participants at Board Meetings

2.1.8. Eligible Providers of Primary Medical Services

2.1.9. Key Policy Documents

3. Access to the Governance Handbook

3.1. The ICB Governance Handbook will be published on the ICB website for transparency and ease of access (www.lancashireandsouthcumbria.icb.nhs.uk)

3.2. The ICB Governance Handbook will be updated regularly as a routine reference guide to how governance arrangements in the ICB will operate.

4. The Functions and Decisions Map

4.1. The functions and decisions map is a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. It also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

4.2. The Lancashire and South Cumbria ICB functions and decisions map is provided at **Appendix A.**

5. The Scheme of Reservation and Delegation (SoRD)

5.1. The Scheme of Reservation and Delegation (SoRD) sets out those decisions that are reserved to the board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with, and be consistent with, the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated.

5.2. The SoRD incorporates an operational/Financial scheme of delegation (SOD) that determines delegated financial limits for the Committees of the ICB, the Executive Leadership Team, Finance Officers, and Other Officers.

5.3. The Lancashire and South Cumbria ICB Scheme of Reservation and Delegation (SoRD) is provided at Appendix B.

6. The Standing Financial Instructions (SFIs) and Losses and special Payment Guidance

6.1. The Standing Financial Instructions (SFIs) are part of the ICB's control environment for managing the organisation's financial affairs and they are designed to ensure regularity and propriety of financial transactions.

6.2. SFIs define the purpose, responsibilities, legal framework and operating environment of the ICB. They enable sound administration, lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services.

6.3. The Lancashire and South Cumbria ICB Standing Financial Instructions (SFIs) are provided at Appendix C and the Losses and Special Payments Guidance are provided at Appendix D.

7. The Terms of Reference for committees of the board

7.1. The board has established the following committees:

- Audit Committee
- Remuneration Committee
- Quality Committee
- People Board
- Public Involvement and Engagement Advisory Committee
- Finance and Performance Committee
- Primary Care Commissioning Committee

7.2. The Terms of Reference for each of these Committees are provided at Appendix E.

8. Other Decision-making Groups

Health and Wellbeing Boards

8.1. A number of decisions and functions are delegated to be exercised jointly by the ICB and each of the unitary or upper tier local authorities in Lancashire and South Cumbria.

8.2. These are set out in the ICB SoRD and relate to the Better Care Fund, which is a pooled fund hosted by the unitary or upper tier local authority and transacted through section 75 pooled funding arrangements between the ICB and each of the unitary or upper tier local authorities in Lancashire and South Cumbria. Section 75 of the NHS Act 2006 allows partners (NHS bodies and councils) to contribute to a common fund which can be used to commission health or social care related services.

8.3. In each unitary or upper tier local authority, the following groups exercise the decision-making:

- Blackburn with Darwen Health and Wellbeing Board
- Blackpool Health and Wellbeing Board
- Cumbria Health and Wellbeing Board
- Lancashire Health and Wellbeing Board

8.4. The decisions and functions delegated to these Health and Wellbeing Boards are:

- Agree priorities and Investment plans for the Better Care Fund created jointly by the ICB and each relevant unitary or upper tier local authority
- Agree the strategic direction of the Better Care Fund and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners
- Approve arrangements for risk sharing and/or risk pooling
- Approve quarterly and year-end report against plan for submission
- Agree pooled fund payment schedules
- Approve annual statement of accounts
- Oversight of Regional and National Assurance process

9. The Roles and Responsibilities of Board Members

9.1. The board is composed of the following members:

- Chair
- Chief Executive

- 2 Partner Members - NHS Trusts and Foundation Trusts
- 1 Partner Member - Primary Medical Services
- 1 Partner Member - Local Authorities
- 6 Non-Executive Members
- Chief Finance Officer
- Medical Director
- Chief Nurse

9.2. All members of the unitary board, including partner members, are collectively and corporately accountable for organisational performance. The purpose of the board is to govern effectively and in doing so, build patient, public and stakeholder confidence that their healthcare is in safe hands. The board are responsible for:

- formulating a plan for the organisation
- holding the organisation to account for the delivery of the plan; by being accountable for ensuring the organisation operates effectively and with openness, transparency and candour and by seeking assurance that systems of control are robust and reliable
- shaping a healthy culture for the organisation and the system through its interaction with system partners.

9.3. As members of the board, each individual will:

- Work collaboratively to shape the long-term, viable plan for the delivery of the functions, duties and objectives of the ICB and for the stewardship of public money.
- Ensure that the board is effective in all aspects of its role and appropriately focused on the four core purposes, to:
  - improve outcomes in population health and healthcare;
  - tackle inequalities in outcomes, experience and access;
  - enhance productivity and value for money and help the NHS support broader social and economic development.
- Be champions of new governance arrangements (including with the Integrated Care Partnership), collaborative leadership and effective partnership working, including with local government, NHS bodies and the voluntary sector.
- Support the Chair and the wider board on issues that impact organisations and workforce across the Integrated Care System, such as integration, the People agenda, Digital transformation, Emergency Preparedness, Resilience and Response (EPRR) and Covid-19 challenges.
- Play a key role in establishing new statutory arrangements for the Integrated Care System to ensure that the ICB meets its statutory duties, building strong partnerships and governance arrangements with system partners, including the ability to take on commissioning functions from CCGs and NHS England.

- Actively contribute and participate in Board Development activities and relevant Leadership development programmes

9.4. The specific roles and responsibilities of each of the board members are:

The Chair

9.5. The independent, non-executive Chair of the ICB is accountable to the NHS England Regional Director for the development and delivery of the plan of the ICB.

9.6. The Chair is accountable for ensuring there is a long-term, viable strategy in place for the delivery of the functions, duties and objectives of the ICB and for the stewardship of public money. The Chair champions action to help meet the four core purposes of Integrated Care Systems: to improve outcomes in population health and healthcare; tackle inequalities in outcomes, experience and access; enhance productivity and value for money and help the NHS support broader social and economic development. The Chair is an ambassador for and champion of effective partnership working with local government and NHS bodies, collaborative leadership and new governance arrangements across the Integrated Care System.

9.7. The Chair ensures that the ICB is properly constituted and focused on improving outcomes in population health and healthcare, and encouraging greater partnership, integration and collaboration, both within the NHS and between the NHS and local government. The Chair has a responsibility to establish and lead the unitary board of the ICB, which has joint collective and corporate accountability for the performance of the organisation, ensuring its functions are effectively and efficiently discharged and for NHS resources deployed to other organisations.

9.8. The Chair provides strong leadership on issues that impact upon organisations and workforce across the system, including integration, the People agenda, Digital transformation, Emergency Preparedness, Resilience and Response (EPRR) and Covid-19 challenges.

Non-Executive Members

9.9. The non-executive members:

- Are accountable to the ICB Chair.
- Have designated areas of responsibilities as agreed with the ICB Chair.
- Have a collective responsibility with the other members of the ICB to ensure corporate accountability for the performance of the organisation, ensuring its functions are effectively and efficiently discharged and its financial obligations are met.

9.10. Non-Executive Members are responsible for specific areas relating to board governance and oversight by

- Bringing independent and respectful challenge to the plans, aims and priorities of the ICB
- Promoting open and transparent decision-making that facilitates consensus aimed to deliver exceptional outcomes for the population

9.11. One of the Non-Executive Members will be the Deputy Chair.

9.12. One of the Non-Executive Members will be the Chair of the Audit Committee, who will also act as the Conflicts of Interest Guardian

9.13. One of the Non-Executive Members will be the Chair of the Remuneration Committee.

9.14. One of the Non-Executive Members will take the role of a senior non-executive member and take a lead role in the appraisal of the Chair.

The Chief Executive

9.15. The Chief Executive is accountable to the ICB Chair and Board for the delivery of the ICB plan. Performance oversight will be provided by the NHS England and Improvement Regional Director.

9.16. The Chief Executive is accountable for the devising and delivering of a 5-year plan for the ICB in conjunction with boards, partners across the ICS and local community, delivering related NHS commissioning and performance arrangements for the entire system and, through this, securing the provision of a comprehensive health service for people in the ICS area.

9.17. The Chief Executive will allocate and manage the NHS budget across the system in line with the plan agreed by the Board, the system's Integrated Care Strategy, the NHS Long Term Plan and NHS People Plan. This includes accountability for ensuring financial balance for the NHS, good value for money for taxpayers and long-term financial health in the system.

9.18. Innovation in the delivery of patient care and particularly in improved access, better patient experiences, increased patient safety - and reduced inequalities in these regards - will be a key priority. The Chief Executive will lead this transformation and encourage activity to accelerate this across the system.

9.19. The role is dependent on strong relationships with local patient communities, their representatives and system-wide partners. The Chief Executive will invest in an engagement and communication plan which builds confidence through routine listening events and involvement in the design of care improvements.

Chief Finance Officer

9.20. The Chief Finance Officer reports directly to the ICB Chief Executive and is professionally accountable to the NHS England and NHS Improvement regional finance director.

9.21. As the strategic financial lead, the Chief Finance Officer is accountable for all matters relating to the financial leadership and financial performance of the ICB.

9.22. The Chief Finance Officer, along with other executive members of the ICB, will also be responsible for ensuring that the ICB implements a robust financial strategy; ensuring that the ICB meets the financial targets set for it by NHS England and NHS Improvement, including living within the overall revenue and capital allocation, and the administration costs limit; and ensuring that system resources are effectively deployed and used to provide the best possible care for the population.

9.23. The Chief Finance Officer will provide financial leadership and influence across the ICS. They will ensure that opportunities to drive improvements in population outcomes are realised, which includes collaborating and providing financial leadership with key partners (across health, care and wider), to break down barriers, drive innovation and achieve agreed deliverables.

Medical Director

9.24. The Medical Director reports directly to the ICB Chief Executive and is professionally accountable to the regional medical director.

9.25. The Medical Director, along with the Chief Nurse is accountable for all matters relating to the relevant professional colleagues across the clinical and care workforce employed by the ICB. They will also be designated accountable for statutory and non-statutory functions that the ICB will need to perform.

9.26. The Medical Director will have an influential executive role and shared accountability for the development and delivery of the long-term clinical strategy of the ICB, ensuring this reflects and integrates the strategies of all relevant partner organisations within the ICS.

9.27. With the Chief Nurse, the Medical Director will lead on overseeing quality of health services within the ICS including sharing intelligence and working with other key partners and regulators across and outside the system to improve quality of care and outcomes.

9.28. With the Chief Nurse, the Medical Director will be accountable for securing multi-professional clinical and care leadership in delivery of the ICB's objectives and form part of the wider network of clinical and care leaders in the region and nationally. With the ICB board they will ensure that population health management, innovation and research support continuous improvements in health and well-being including digitally enabled

clinical transformation and the clinical and care elements of a sustainable People Plan for the ICS workforce.

Chief Nurse

9.29. The Chief Nurse reports directly to the ICB Chief Executive and is professionally accountable to the regional chief nurse.

9.30. The Chief Nurse will support the development and delivery of the long-term plan of the integrated care board (ICB). They will ensure this reflects and integrates the strategies of all relevant partner organisations of the ICB, with a particular focus on developing a shared clinical strategy.

9.31. The Chief Nurse, along with the Medical Director, is accountable for all matters relating to the relevant professional colleagues across the clinical and care workforce employed by the ICB. They will also be designated accountable for statutory and non- statutory functions that the ICB will need to perform.

9.32. The Chief Nurse will have an influential executive role and shared accountability for the development and delivery of the long-term clinical strategy of the ICB, ensuring this reflects and integrates the strategies of all relevant partner organisations within the ICS.

9.33. The Chief Nurse, along with the Medical Director, will be accountable for providing high quality clinical and professional leadership of the ICB’s activities. This includes ensuring that clinical and care professional leadership is embedded at all levels of the ICS as set out in the Clinical and Care Professional Leadership Guidance. With the ICB board they will ensure that population health management, innovation and research support continuous improvements in health and well-being including digitally enabled clinical transformation and the clinical and care elements of a sustainable People Plan for the ICS workforce

The Partner Members

9.34. Each Partner Member:

- Is accountable to the ICB Chair.
- Has a collective responsibility with the other members of the ICB Board to ensure corporate accountability for the performance of the organisation, ensuring its functions are effectively and efficiently discharged and its financial obligations are met.
- Will work alongside the Chair, non-executives, executive directors and other partner members as an equal member of a unitary board.
- Will bring a range of knowledge and professional expertise as well as a high level of understanding and experience from their sector to the work of the board.

9.35. Each Partner Member brings knowledge and a perspective from their sector, but they do not act as a delegate of their sector and are not appointed as representatives of the interests of any particular organisation or sector.

The Partner Members – NHS Trusts and Foundation Trusts

9.36. One of these roles will fulfil the requirement of **Partner Member for Mental Health** by having specific knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness and the provision of mental health services.

9.37. One of these roles will fulfil the requirement of **Partner Member for Acute and Community Services** by having specific knowledge and experience of the provision of acute and community services.

9.38. Together the two Partner Members must be able to bring the full range of perspectives across emergency, acute, mental health and community provision; and must be able to engage and maintain dialogue with the social enterprise sector as key partners within the ICS to understand their perspective.

Partner Member – Providers of Primary Medical Services

9.39. Key responsibilities will include engaging with providers of other primary care services to bring wider primary care perspectives, multi-disciplinary ways of working and a breadth of clinical practice; and chairing or attending (as appropriate) multi-stakeholder forums and committees, such as the Integrated Care Partnership and any Clinical and Care Professional fora.

Partner Member – Local Authorities

9.40. Key responsibilities will include bringing a local authority perspective of delivery within the Lancashire and South Cumbria system, with the ability to draw upon consistent and sustained experience from across the sector including the care agenda, public and population health, and policy areas related to wider health determinants and prevention. In addition, this Partner Member will bring a local authority perspective and knowledge of geographical diversity, perspectives and a variety of views relevant to the system's urban or rural contexts.

10. Regular Participants at Board Meetings

10.1. The board may invite specified individuals to be participants or observers at its meetings in order to inform its decision-making and the discharge of its functions as it sees fit.

10.2. Participants will receive advance copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a

meeting by the Chair. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote.

10.3. The following may be invited as participants:

- Other Very Senior Officers of the ICB and its place-based partnerships
- A Director of Adult Social Care
- A Director of Public Health
- Voluntary, community, faith and social enterprise sector
- Healthwatch
- Any other person that the Chair considers can contribute to the matter under discussion

11. The list of eligible providers of primary medical services

11.1. The Partner Member – Providers of Primary Medical Services is jointly nominated by providers of primary medical services for the purposes of the health service within the ICB's area, and that are primary medical services contract holders responsible for the provision of essential services, within core hours, to a list of registered persons for whom the ICB has core responsibility.

11.2. The list of relevant providers of primary medical services for this purpose is provided at Appendix F.

12. Key policy documents

12.1. A number of key policy documents are referenced in the Constitution and/or in the Terms of Reference for the committees of the board:

- Conflicts of Interest Policy and Procedures
- Standards of Business Conduct Policy
- Public Involvement and Engagement Policy

12.2. These policies are provided at Appendix G to I.

13. Memorandum of Understanding

13.1 A Memorandum of Understanding (MOU) between NHS Lancashire and South Cumbria Integrated Care Board and NHS England (NW Region) is provided at Appendix J.

13.2 The MOU sets out the arrangements between NHS England (NHSE) and the system in respect of the System Oversight Framework. It provides clarity on the expected oversight arrangements, support offers and escalations processes in respect of the four segmentations of the framework. In addition, the MOU describes the relationships

between the system and NHSE regional team. It is expected that this relationship will differ according to the System, levels of delegation and maturity. It is anticipated that whilst this document begins to set out these arrangements, a more detailed Operating Model will further develop these relationships and ways of working for the future.

13.3 The MOU is between the Lancashire and South Cumbria Integrated Board and NHS North West region, on behalf of NHS England. It is effective as of 1st July 2022.

- The MOU sets out the principles, describes the relationships and the key interfaces between the ICB and NHSE that underpin how the ICB and NHSE will work together to discharge their duties.
- Designing the MOU will be a collaborative exercise that will help facilitate a discussion and provide clarity on how duties will be discharged.
- It will help with outlining the key agreed ways of working together to ensure that people across the system have access to high quality, equitable health, and care services.
- The detailed arrangements will be kept under regular review and the Agreement will be updated periodically to show those developments.
- The MOU is intended to align and be supported by the NHSE System Oversight Framework, the Operating Model, the ICB Constitution and other published guidance (without duplicating content).

Appendices

All appendices as referenced in the contents on page 2 of this document, and as follows, can be found in the following location on the ICB website:

[Lancashire and South Cumbria Integrated Care Board :: Corporate Governance Handbook (icb.nhs.uk)]

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