**Central Lancashire Shadow ICP Board**

**Terms of Reference**

1. **Introduction**

1.1The (shadow) Integrated Care Partnership (ICP) Board (hereafter referred to as the “Board”) is established as a Central Lancashire health economy partnership Board. The shadow Board will operate under these Terms of Reference until a formal board is in place. During the shadow period (development phase), the ICP Board will operate as a sub-committee of partner organisations (in shadow form). Central Lancashire partners will work together to develop the evidence of the expected benefits/risks of an integrated care approach in our area, and put in place the building blocks for a newly integrated health and social care economy.

1.2 The Board will function as a partnership, and will set strategic direction, agree priorities and undertake operational planning for Central Lancashire’s health and social care economy. The Board will oversee delivery and hold the local leadership to account in the implementation of the development of an Integrated Care Partnership.

1.3 These Terms of Reference set out the Board’s membership, its role, responsibilities and reporting arrangements, and shall be agreed by all members.

1.4 At all stages during the shadow process, individual organisational Boards retain statutory status (where applicable) and existing accountability. Whilst elements of decision making may be conferred by partner boards during the operational phase, within the current legislative framework, actual accountability will remain with member boards.

1.5 During the shadow phase, the key task for organisational Boards will be to agree what powers will be delegated to the ICP Board to provide it with authority to further develop the ICP and to oversee delivery of priority workstreams.

**2.0 Role of the (shadow) Board**

2.1 The Board will provide strategic leadership and oversight to support achievement of a shared vision and objectives through the delivery of a range of programmes of work. These programmes will be required to:

* Transform local health and social care services
* Integrate services
* Lead a collective approach to system resilience and risk
* Apply leadership to central Lancashire challenges

2.2 The Board will discharge its collective accountability for delivery to respective partner organisations through the representation of appropriate executive officers on the Board.

2.3 The Board will consider investment decisions collectively, and agree the use of any nationally drawn down monies such as ‘Vanguard’ funding.

2.4 The Board will operate through an informal shared leadership structure for the initial phase of development.

2.5 The Board will support the development of leadership and devolved decision making to establish a more formal leadership structure in the next phase of development.

2.6 The Board will negotiate potential conflicts of interest between system needs and priorities, and individual / organisational needs and priorities.

1. **Membership**

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| **Organisation** | **Members** | **In attendance (as and when required)** |
| **Chair** | | |
| **Medical Director (appointed as Clinical Lead for the ICP)**  *\*The need for this position is currently under review* | | |
| **NHS Chorley and South Ribble CCG / NHS Greater Preston CCG** | 4 representatives (e.g. AO, CFO and each Chair) | SRO workstream leads / functional leads |
| **Lancashire Teaching Hospitals NHS Trust** | 3 representatives (e.g. CEO, CFO, Chair) | Company Secretary / estates leads |
| **Lancashire Care NHS Foundation Trust** | 3 representatives (e.g. CEO, CFO, Chair) | Company Secretary / estates leads |
| **Programme management** | Director | Minutes / meeting administration |
| **Lancashire County Council** | 2 representatives (e.g. Director and Chair HWB Board) |  |
| **Central Lancashire Health and Wellbeing Partnership** | Chair |  |
| **GP collaborative as providers** | 2 Reps (I for each CCG) |  |
| **ICS** | Representative |  |
| **VCFS Collaborative** | Representative |  |
| **Professor of Social Care, Manchester Metropolitan University** | Co-opted Member |  |

*\*Membership should be regularly reviewed with options to extend to the voluntary, community and faith sector, as well as the ambulance service, GP collaborations, and other partners beyond the developmental stages.*

1. **Attendance**

4.1 Members would normally attend meetings and it is expected that members will attend a minimum of 75% of meetings per annum, barring any exceptional circumstances. If a member is unable to attend members can nominate a deputy to attend on their behalf and this will be formally noted in the meeting minutes.

1. **Quorum**
   1. The meeting will achieve quorum if a minimum of 3 members are present. The onus lies with each organisation to ensure they are represented.
   2. Should a member not be able to attend a Board meeting, apologies in advance of the meeting must be provided to the Board administrator and notified to the Board Chair.
   3. In ensuring an appropriate quorum, the Board will take account of, and work in line with, a Conflicts of Interest Policy and associated arrangements for managing conflicts of interest.
2. **Frequency**

6.1 The Board shall meet on an ad-hoc basis, and not less than monthly. The Chair of the Board may arrange extraordinary meetings at their discretion.

**7.0 Duties**

7.1 The Board will have responsibility for creating an Integrated Care Partnership (ICP). The role of the ICP will be to drive forward system transformation and develop new models of care.

7.2 The Board will agree the priorities for ICP development with a focus on the development of commercial contracting vehicles for delivery.

7.3 The Board will agree a Memorandum of Understanding (MOU) as a “contract” for the delivery of shared objectives, risks and reward.

7.4 The Board will have a clear vision and set of shared objectives, and a commitment to using resources differently to improve population level outcomes.

7.5 The Board will develop shadow population based capitated budgets and shadow place-based capitated budgets.

7.6 The Board will oversee the development of a joint framework for workforce planning, which supports integrated roles and responsibilities.

7.7 The Board will seek assurance for delivery on key programmes of work, including ‘Our Health Our Care’, ICP development, wider primary care at scale, hospital sustainability and alliance contracting.

7.8 The Board will ensure workstreams are managed within the agreed performance management framework and monitored by the agreed metrics/measurable benefits and outcomes of the ICP programme.

7.9 The Board will monitor progress, issues, concerns and barriers of the workstreams, and hold them to account for delivery of agreed implementation plans and outcomes.

7.10 The Board will assure itself and seek assurance that clinicians, professionals, social workers and patient and carers are engaged in the co-design of the new system and communicated with appropriately.

7.11 The Board will develop a wide ranging programme of leadership development to support a shadow ICP leadership team at all levels, with the aim of developing a common organisational development strategy for the emerging ICP.

**8.0 Declarations of interest**

8.1 Individuals contracted to work with, or appointed to the Board, will comply with the CCGs’ Standard of Business Conduct Policy, including the requirements for declaring conflicts of interest.

8.2 In order to facilitate this process, declarations of interest will be a standing item on all agendas and copies of the minutes will be held in the Board administration office for the purposes of maintaining the register of interests.

8.3 All new declarations of interest must be notified to the Chair within 28 days of a member taking office of any interests requiring registrations, or within 28 days of a change to a member’s registered interests. Copies of these notifications should be sent to the Board Administrator.

**9.0 Review**

9.1 These Terms of Reference will be reviewed as needed to support the development of the shadow ICP Board, and no less than six-monthly.