Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	28 July 2021
Executive Member:	Cllr Eleanor Wills, Executive Member for Adult Social Care & Population Health
Clinical Lead:	Dr Ashwin Ramachandra, Co-chair Tameside CCG
Reporting Officer:	Jessica Williams, Director of Commissioning
Subject:	**DEVELOPMENT OF AN INTEGRATED CARE SYSTEM IN T&G**
Report Summary:	This report articulates the work programme which is underway to deliver the required changes in T&G in response the development of local NHS Integrated Care Systems.
Recommendations:	To note the content of the report and approve the Draft Terms of Reference in the **Appendix** for the T&G Integrated Care Transition Board. Recognise that this work programme is progressing at pace despite the lack of final legislation and this creates associated risk. **Additional Comments** The ICS is still very early in its development and the formation of a T&G Integrated Care Transition Board will support the emergence of the ICS as a statutory body as more detail and clarity is received. Therefore, at this stage there are no financial implications to report. However, throughout the development of the ICS, the creation of a sustainable financial model will be paramount whilst also ensuring stringent due diligence in the close down of the CCG and the transfer of resources to the new commissioning architecture.
Legal Implications: (Authorised by the Borough Solicitor)	This sets out early thinking and a shadow approach to provide an overview and structure to the programme to deliver the NHS Integrated Care System on the basis of the successful integrated Strategic Commissioning Board. Whilst it is noted that in the draft terms the Chair of the T&G Partnership Board is the accountable person to GMICS in T&G for Health and Care it is not clear what exactly it is the Chair accountable for and what are the ramifications of that accountability. It will be necessary to understand both the legislation and the funding and delegations to be provided by GMICS. It should be noted that this joint committee falls away when the Tameside and Glossop CCG ceases to exist in law.
How do proposals align with Health & Wellbeing Strategy?	In line with the policy objective of the corporate plan for longer and healthier lives.
How do proposals align with Locality Plan?	Meets the ambition of the Locality Plan for improved healthy life expectancy.

How do proposals align with the Commissioning Strategy?	Changes to the model of commissioning will be a part of the GMICS development.
Recommendations / views of the Health and Care Advisory Group:	N/A
Public and Patient Implications:	Commitment to reduce service duplication. Increase clarity of service provision and maximise outcomes for the population.
Quality Implications:	Changes to the model of Quality assurance will be a part of the GMICS development.
How do the proposals help to reduce health inequalities?	Clear focus on addressing health inequalities.
What are the Equality and Diversity implications?	None identified
What are the safeguarding implications?	There will be changes to the statutory responsibility for safeguarding as this moves from T&G CCG to GMICS.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	None identified
Risk Management:	A separate risk register has been developed to manage this work programme, this is review at the T&G ICS Working Group.
Access to Information:	The background papers relating to this report can be inspected by contacting the report writer, Martin Ashton, Associate Director of Commissioning  Telephone: 07387 056042  e-mail: martinashton@nhs.net

1. INTRODUCTION

1.1 Pioneering work has been underway for many years in Tameside & Glossop (T&G) to integrate the local health and social care system. The next stage of this transformation needs to respond to the recent White Paper: *Integration and Innovation - working together to improve H&SC for all* which sets out legislative proposals for changes to the health & care system including a duty to collaborate across the NHS, social care and public health systems.

1.2 The White Paper builds on the ambition of the NHS Long Term Plan and intends to remove the barriers that stop the system from being truly integrated. It seeks to drive increased NHS Provider collaboration alongside increased partnership between wider systems including NHS, local authority, social care, public health and the voluntary sector.

1.3 The white paper identifies four overarching aims:

1. Improving population health and healthcare
2. Tackling unequal outcomes and access
3. Enhancing productivity and value for money
4. Support broader social and economic development.

2. TRANSITION TO AN ICS AND THE CLOSE-DOWN OF TAMESIDE AND GLOSSOP CCG

2.1 The ambition of the White Paper aligns clearly to the founding principles of the GM Health and Social Care Partnership (GMHSCP) which established and progressed unique health devolution agreements. The plans in GM are therefore not expected to move notably from the original objectives of the GMHSCP. GM partners must however transition to a statutory Integrated Care System (ICS) comprising an NHS ICS body and Health and Care Partnership.

2.2 The ICS NHS body will be responsible for the day to day running of the ICS, while the ICS Health and Care Partnership will bring together systems to support integration and develop a plan to address the systems' health, public health, and social care needs.

2.3 CCG functions will move to newly created ICS from April 2022 (subject to legislation), although shadow arrangements may be in place as early as Q3 2021/22. In GM this means that all 10 CCGs will be merged with the functions transferred into a receiving organisation within the GMICS. The GMICS NHS Body will take on the commissioning functions of the GM CCGs and some of those of NHS England within its boundaries.

2.4 The white paper requires the continuation of Health and Wellbeing Boards but is permissive regarding place-based arrangements between local authorities, NHS Providers and wider partners.

2.5 The White Paper outlines the requirement for an ICS to be co-terminous with Local Authority boundaries. This would place Glossop within a Derbyshire ICS, rather than the current GM arrangements. The ICS design framework published in June 2021 states that "*systems should establish and support place-based partnerships with configuration and catchment areas reflecting meaningful communities and geographies that local people recognise".* Decisions on ICS boundaries are expectedly imminently.

3. EMERGING GMICS OPERATING MODEL

3.1 T&G colleagues are working closely with GM Health & Social Care Partnership and the constituent organisations to develop a GMICS operating model. The proposed model builds

on the existing system but places much greater emphasis on six major programmes of activity and focus:

1. Maintaining physical, social and mental wellbeing.
2. Creating more consistent evidence based preventive and proactive primary care.
3. Greater integration of the community based reablement, residential, rehabilitative, palliative and social care services (working to eliminate the traditional divide between hospital and out of hospital services).
4. Coordinating and improving the urgent and emergency care service response by mandating health and care providers to develop more coherent pathways of care and enabling patients to access the right level of care sooner.
5. Delivering more consistent planned care and delivering the planned care recovery programme.
6. Further developing GMs access to and delivery of world class specialised care and building a hugely capable innovation capability in Health Innovation Manchester.

3.2 This includes the following GMICS expectation of locality architecture:

- Neighbourhoods need some form of management structure or group which aligns and builds on the Primary Care Network (PCN) function.
- Locality structures would feature a consistent locality operating model.
- Locality Provider collaborative in place.
- Provider collaboratives that operate across GM with formal governance to plan and deliver diagnostic and acute care.
- Capability at GM level to discharge the functions, governance and legal requirements of an ICS.
- A system of joint planning convened at GM level but with constituent localities and collaboratives fully engaged to identify the synergies and connections between allocated resources.

3.3 To deliver the ambition within the White Paper the GM Health and Social Care Partnership have identified four priority areas to improve health and wellbeing:

1. Tackling inequalities and transforming population health
2. Guaranteeing Constitutional Standards and eliminating unwarranted variation in care
3. Connect health, social care, academia and industry to discover, develop and deploy innovation at pace and scale
4. Achieve comprehensive system sustainability across health and social care for the long term.

4. TAMESIDE AND GLOSSOP INTEGRATED CARE SYSTEM

4.1 Across Tameside and Glossop (T&G) we continue to work across the system to design and implement changes needed locally in response to the formation of the GMICS. The systems we have in place, following several years of integrated working are strong and we are committed to retaining these where they continue to add value. We will continue to uphold the concept of primacy of place and remain committed to the eight priorities of the Corporate Plan.

4.2 Our ambition is that T&G is a happy, healthy and ambitious place to live, where people choose to live and work. We want to co-develop person-centred, resilient asset-rich communities that support residents to live great lives. Our principal objective is to integrate services around people and their needs. This will involve furthering the pioneering work undertaken in T&G to integrate health and care services and creating a system of co-located professionals from all public services working together as one integrated public service across our locality and within our neighbourhoods.

4.3 The primary purpose of the health and care system has been to provide periodic treatment for acute illness; our health services are high-quality and manage ill health to an extremely

high standard. However, to be successful we need to further develop a population health system which reduces the demand on health services.

4.4 We will work to the following place-based principles to support integration and collaboration at all levels.

Principles	We will…
Partnership	✓ We will be accountable to the local population and to each other. ✓ We will co-design and co-produce services with residents and community partners.
Powered by people	✓ We will empower our population and support them to take responsibility for their own health and wellbeing. ✓ We will recognise and develop resident, voluntary, clinical, political and managerial leadership. ✓ We will empower our workforce to work in collaboration across organisational, professional and service boundaries.
Person-centred	✓ We will take a proactive and preventative approach, intervene early and respond to the person in the context of their community. ✓ We will develop place-based approaches to tackling the social determinants of health that build on the assets within our communities.
Productive	✓ We will implement ways of working that support collaboration not competition. ✓ We will work together to make best use of financial, workforce, estate and other resources. ✓ We will maximise social value and jointly manage the system budget sharing risks, deficits and surpluses.
Progressive	✓ We will create a 'can do' culture with a focus on innovation and continuous improvement. ✓ We will develop a strong learning culture where new ways of working are reviewed and evaluated.

4.5 There will be three principle components to our proposed local integrated care system; design, delivery and assurance. This will be supported by integrated governance built around a T&G Partnership Board, a T&G Provider Partnership and 5 x neighbourhood partnerships.

AN INTEGRATED SYSTEM AT EVERY LEVEL IN T&G

ORGANISATIONAL FORM	OVERVIEW
DELIVERY: **5 x T&G Neighbourhood Partnerships** **Integrated neighbourhood delivery model*	*Clinical, political, managerial and VCFSE leadership provided by multi-agency partners. *Central role for PCNs. *Development of cross-system neighbourhood priorities. *Multi-agency neighbourhood collaboration recognising wider determinants of health. *Proactive and preventative approach, intervening early and responding to the person in the context of their community.
DELIVERY: **T&G Provider Partnership** **Includes health and care delivery partners* **Mutually accountable to T&G Partnership Board for the delivery of services and outcomes.*	*Collaborative of T&G services, principally based in communities. *Identifies and agrees priorities for neighbourhood partnerships and holds them to account. *Provides infrastructure for neighbourhood partnerships including workforce, estate and digital infrastructure. *Drives proactive and preventative approaches to the wider determinants of health & Public Sector Reform. *Provides, sub-contracts and commissions services with partners *Collaboration not competition; build not buy. *Vehicle for receiving funding, transforming and delivering services.
DESIGN: **T&G Partnership Board** **System design board to address all determinants of health* **Integrated governance holds system to account*	*Strategic partnership board to include political, clinical, managerial and VCFSE leadership. *Oversight of financial allocations to further strategic priorities and ensure system financial sustainability. *Population health management. *Understands and responds to the role of the wider determinants of health including education, employment, crime, housing, leisure, transport etc. *Incorporates integrated strategic commissioning function including Quality, assurance, policy and transformation.
DESIGN: **Greater Manchester Integrated Care System (ICS)**	**GMICS: Statutory NHS Body and Board:** Responsible for the day to day running, planning and resource allocation, accountable for NHS spend, performance and quality. Board to include as a minimum ICS Chair & Chief Executive, NHS trusts, General Practice, Local Authorities. **GMICS Health and Care Partnership:** *Wider system integration (may additionally include VCFSE, Housing, Social Care etc.).

ASSURANCE

5. DELIVERY: T&G NEIGHBOURHOOD PARTNERSHIPS

5.1 Neighbourhoods remain the principal building block for the delivery model; our primary objective is to integrate services around local people, creating a system of multi-agency professionals from all public services working together as one integrated public service neighbourhood team. Delivery will be person-centred and take a proactive and preventative approach, intervening early and responding to the person in the context of their community.

5.2 Neighbourhood partnerships will include clinical, political, managerial and voluntary leadership with a key role for Primary Care Networks. Representatives from each neighbourhood partnership will sit on the T&G Provider Partnership Board. The T&G Provider collaborative will be accountable for integrated neighbourhood delivery which will drive public service reform. The neighbourhood partnership will support the interface with wider public sector and VCFSE partners.

5.3 Neighbourhood partnerships will share overarching principles and key partners such as Housing, Children's Services and Leisure services, but will also have specific local differences relevant to the needs and assets of the residents and communities in each neighbourhood.

6. DELIVERY: T&G PROVIDER PARTNERSHIP

6.1 The Tameside and Glossop Provider Partnership will be co-designed as a formal Provider Partnership Alliance for Tameside and Glossop. It will incorporate NHS and non-NHS organisations working together and holding each other to account using place-based budgets to design, transform, deliver, assure, sub-contract and commission pathways, services and cross-system initiatives.

6.2 Led by T&G Integrated Care NHS Foundation Trust (ICFT), the Provider Partnership will be accountable to the T&G Partnership Board, but will operate independently with distinct leadership and supporting governance making key decisions which drive delivery at pace and scale.

6.3 The Provider Partnership model is being developed by a multi-agency steering group via a series of scheduled workshops from June to September. It will, through strong place-based partnerships, work with local government, and wider stakeholders such as housing and care providers to support communities to tackle the wider social and economic determinants of health.

6.4 The Provider Partnership will play a leading role in workforce strategy, embedding clinical leadership and ensuring a diverse workforce and leadership representative of our local population. All of these models of care and developments will continue to be underpinned by active engagement with our population to support person-centred self-care and the building of strong relationships with the voluntary and community sector.

6.5 Through the ICFT, the locality Provider Partnership will link through to the GM Provider Collaboratives to support both horizontal and vertical collaboration across providers to support standardisation of services, improvements in care pathways and driving down health inequalities that exist for our population.

7. DESIGN: T&G PARTNERSHIP BOARD

7.1 **DESIGN:** The T&G Partnership Board will be built on the principles and working processes of our T&G Strategic Commissioning Board (SCB) which is a well-established effective legal construct that brings together the commissioning of a wide range of health and social care functions. The governance framework for the T&G SCB is framed under the Local Government Act 1972. As a statutory Joint Committee formed by the two statutory organisations all members must comply with the requirements set by the Local Government Acts 1972 and 2000 and the Council's Constitution. The current governance works well and we are committed to maintaining this where legislation allows following the merger of GM CCGs. The SCB will finish and the T&G Partnership Board will be formed as a new Joint Committee based on the principles of the SCB in collaboration with GMICS.

7.2 The T&G Partnership Board will be chaired by the place-based lead as the accountable person to GMICS in T&G for Health and Care. The place-based lead will (subject to legislation and guidance):

- Be the accountable person to GMICS in T&G for Health and Care; overseeing the responsibilities delegated to T&G by GMICS.
- Have oversight of the combined system resources and assets and use this is a basis for joint action.
- Have system oversight of quality, safety and safeguarding across T&G.
- Chair the T&G Partnership Board and convene system partners around a common purpose and commitment to place.
- Sit on the GMICS Board as the T&G representative and advocate for the local system and population.
- Nurture collective and distributed leadership across the local system.

- Embed a culture of openness and transparency within the local system to drive improvements in population health.

7.3 The board will include a wide range of partners with a responsibility for population health, this will include political, clinical, professional, managerial, VCFSE and resident representation. Where appropriate members will be 'selected and elected' and role profiles for Board members will be agreed. Derbyshire ICS representation will be required to ensure the best interests for Glossop residents.

7.4 T&G has extensive experience in overseeing integrated funding and we intend to retain these local processes. We recognise that the financial model is likely to require a blended approach and remain committed to making decisions about investment for our local population in T&G. This will be undertaken at the T&G Partnership Board.

7.5 The T&G Partnership Board will:

- Have overall accountability for the integrated system and the triple aim of:
  - ✓ Better health & wellbeing for everyone
  - ✓ Better quality of health services for all
  - ✓ Sustainable use of NHS resources.
- Establish shared commissioning intentions for the system and provide a mechanism for locality priorities to be agreed.
- Provide system-oversight of a joint place-based budget which will be used to drive shared population health outcomes.
- Provide a forum for strategic clinical, professional, managerial and resident oversight.
- Manage shared risk.
- Provide a key interface with the Health & Wellbeing Board(s).

7.6 It is recognised that many T&G CCG functions will sit at a GM level within the GMICS. It has not yet been agreed what form is required to discharge the CCG legacy functions in T&G. It is expected that some of these functions will transfer into a Strategic Commissioning function aligned to TMBC and some will transfer into the Provider Partnership.

8. ASSURANCE AT EVERY LEVEL

8.1 Each NHS organisation has individual responsibilities to ensure the delivery of high quality care. ICS NHS bodies will also have statutory duties to act with a view to securing continuous improvement in quality. We expect them to have arrangements for ensuring the fundamental standards of quality are delivered including to manage quality and safety risks and to address inequalities and variation; and to promote continual improvement in the quality of services, in a way that makes a real difference to the people using them. ICSs are expected to build on existing quality oversight arrangements, with collaborative working across system partners, to maintain and improve the quality of care.

8.2 A system oversight and quality improvement function will sit within GMICS providing assurance that local systems are successfully monitoring and assuring themselves against the NHS's Triple Aim with clear roles and accountabilities for quality oversight and well-defined processes for managing quality performance and quality risks.

8.3 Whilst much of the accountability for Quality and safeguarding functions will sit with GMICS it is likely that a hub and spoke model will be implemented. There is a need to continue working collaboratively within T&G around this agenda. Operational and strategic leadership of this agenda will be required at all levels.

9. FINANCIAL PRINCIPLES

9.1 T&G has extensive experience in overseeing integrated funding and we intend to retain the learning from these local processes. We recognise that the financial model is likely to require a blended approach to funding flows of NHS money. This will include direct allocation to NHS Trusts, allocation to Provider Collaboratives and to agreed NHS / Local Authority arrangements in localities; however we are committed to making decisions about investment for our local population in T&G. This will be undertaken at the T&G Partnership Board where 'risk and gain share' agreements will be approved.

9.2 Shared financial principles locally recognise the need for:

- Ensuring best value locally from all investments, and maximising social value.
- Targeting inequalities with financial commitments informed by data and intelligence.
- Alignment of health and care funding with wider public sector funding.
- Shared stewardship of the money spent at each level overseen by the T&G Partnership Board.
- Local oversight allowing savings realisation to be held locally.
- Commitment of all Providers to full transparency and acceptance of the need to audit investment.

9.3 The formation of an ICS as a statutory body is anticipated to address the current limitations of Section 75 pooled budget legislation. However, the principles and learning from the T&G Integrated Commissioning Fund still stand and it is important that these are effectively reflected in the construct of the new funding flows and legal architecture.

9.4 Different scenarios for receipt of direct funding will be stress-tested to guard against potential concerns of mistrust, conflict of interest and other unintended consequences and in so doing, provide effective safeguards to address the issues, influence wider system working and mitigate risks.

9.5 T&G will work collaboratively to build a financially sustainable model and ensure value for money by working as a GM collective in securing external professional support where needed, for example, legal advice to support the new financial architecture.

10. PROGRAMME GOVERNANCE

10.1 To manage the safe close-down of the CCG and associated system transformation the following system governance has been developed:

- Integrated Care Transition Board (ICTB)
- ICS working group: to provide the overall grip on the work programme (meeting fortnightly).
- 5 x thematic inter-connected subgroups as shown below.

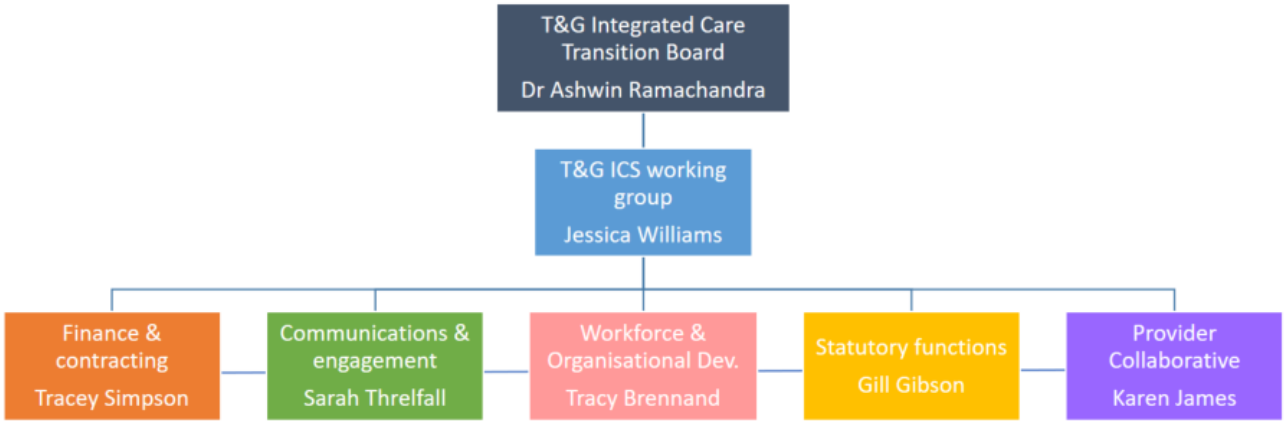
10.2 The Integrated Care Transition Board (ICTB) is the system-wide accountable group to oversee the transition into the GMICS. This involves building on the current locality arrangements to establish a new locality operating model as part of the establishment of a statutory GMICS. Draft terms of Reference can be found in the appendix.

10.3 The ICTB will take place prior to the T&G Strategic Commissioning Board and will be chaired by the Co-chair of T&G CCG. All existing SCB members will be invited with additional representation to be determined but to include as a minimum the Chief Executive T&GICFT NHS Trust, Chief Executive Pennine Care FT NHS Trust, Chief Executive Action Together and a Primary Care Network representative.

10.4 The role of the ICTB is to:

- Take overall responsibility for setting the direction and scope of the ICS Transition Programme.
- Oversee the close down of the CCG utilising appropriate due diligence.
- Consider, advise and approve the future T&G health & care system form that will deliver the defined functions of a Locality within the GMICS.
- Have oversight of all ICS transition activity in T&G by connecting workstreams together.
- Provide guidance and advice as work progresses in relation to options, governance, proposals, risks, communication and decision making.
- Be grounded in the vision and principles of the local Corporate Plan and Locality Plan.
- Oversee the development of and transition to a new T&G Partnership Board.

10.5 The responsibilities of the ICTB will cover the same geographical area as of NHS Tameside and Glossop CCG (that is fully coterminous with Tameside Metropolitan Borough Council and the Glossop locality of Derbyshire County Council). Noting that the White Paper affirms that ICS's should be coterminous with local authority boundaries.



11. KEY RISKS

11.1 Staff below board level have an employment commitment to the ICS. Along with senior staffing changes there is a risk colleagues will leave due to uncertainty, engagement and the length of time it will take before people know if they have a role or what the role may be. This could lead to loss of corporate memory and capacity and capability to deliver.

11.2 The ability to implement a large and complex work programme with short timescales and a stretched workforce.

11.3 A lack of engagement by system stakeholders caused by the lack of dedicated time, understanding and commitment to new organisational forms and functions.

11.4 Receipt of relevant legal advice as part of the CCG close-down transaction and ICS development.

11.5 Fragmentation of local delivery, leadership and financial control following GMICS formation.

11.6 Delays to national and regional guidance which will delay local decision making.

11.7 The change required to shift from a reactive to a proactive system will require cross-system commitment to Organisational Development.

12. KEY NEXT STEPS

- Mapping of CCG functions to future form, this will be informed by spatial level analysis across key functions with GM partners.
- Analysis of potential financial flows from GMICS to localities.
- Define CCG statutory functions affected by the transition & mitigate any associated risks.
- Development of a stakeholder engagement workplan, including affected staff.
- Begin workforce due diligence.
- Delivery of the Provider Partnership steering group workshops, scheduled June – September 2021.
- Ongoing input into GMICS design and associated governance models.
- Work with Derbyshire County Council, High Peak Council, Derby and Derbyshire CCG and GMHSCP to protect the best interests of Glossop residents in any boundary changes.

13. RECOMMENDATIONS

13.1 As set out at the front of the report.

APPENDIX

Tameside & Glossop Integrated Care Transition Board (ICTB)
DRAFT Terms of Reference

1. ROLE OF THE INTEGRATED CARE TRANSITION BOARD

1.1 This is the system-wide accountable group to oversee the transition into the GMICS. This involves building on the current locality arrangements to establish a new locality operating model as part of the establishment of a statutory GMICS.

1.2 The role of the ICTB is to:

- Take overall responsibility for setting the direction and scope of the ICS Transition Programme.
- Oversee the close down of the CCG utilising appropriate due diligence.
- Consider, advise and approve the future T&G health & care system form that will deliver the defined functions of a Locality within the GMICS.
- Have oversight of all ICS transition activity in T&G by connecting workstreams together.
- Provide guidance and advice as work progresses in relation to options, governance, proposals, risks, communication and decision making.
- Be grounded in the vision and principles of the local Corporate Plan and Locality Plan.
- Oversee the development of and transition to a new T&G Partnership Board.

2. GEOGRAPHICAL COVERAGE

2.1 The responsibilities of the ICTB will cover the same geographical area as of NHS Tameside and Glossop CCG (that is fully coterminous with Tameside Metropolitan Borough Council and the Glossop locality of Derbyshire County Council). Noting that the White Paper affirms that ICS's should be coterminous with local authority boundaries.

3. MEMBERSHIP

3.1 This board has a specific, time-limited purpose to oversee the transition to the GMICS and its membership does not determine future membership of the T&G Partnership Board.

3.2 The ICTB will take place prior to the T&G Strategic Commissioning Board and shall consist of the following members:

The Strategic Commissioning Board core members:

- The Chair of the CCG (Chair);
- The five CCG Governing Body GPs;
- The CCG Governing Body Lay Member with responsibility for Commissioning;
- The Single Accountable Officer of the local authority and of the CCG;
- The Council's Executive Leader;
- The Council's Deputy Executive Leader (Children and Families);
- The Council's Executive Member for Finance and Economic Growth;
- The Council's Executive Member for Health, Social Care and Population Health;
- The Council's Executive Member for Housing, Planning and Employment;
- The Council's Executive Member for Lifelong Learning, Equalities, Culture and Heritage;
- The Council's Executive Member for Neighbourhoods, Community Safety and Environment;
- The Council's Executive Member for Transport and Connectivity.

- In addition the following non-SCB members will be invited:
    - Chief Executive T&GICFT NHS Trust
    - Chief Executive Pennine Care FT NHS Trust
    - Chief Executive Action Together
    - Primary Care Network representative.

The following will have a standing invitation to attend the meetings of the ICTB:

- CCG and TMBC Single Leadership Team
- A representative of Derbyshire County Council
- A representative of High Peak Borough Council
- A representative of Derbyshire CCG.

4. STATUTORY FRAMEWORK

4.1 The ICTB is not a statutory body, it is established as a time-limited group and is not intended to replace any of the existing statutory bodies in the locality.

5. MEETINGS AND VOTING

5.1 The ICTB will give no less than five clear working days notice of its meetings. This will be accompanied by an agenda and supporting papers and sent to each member no later than five days before the date of the meeting.

5.2 It is not anticipated that there will be a need for voting. The aim of the Board will be to achieve consensus decision-making wherever possible. However, should a vote be required it will be by a simple majority of members present but, if necessary, the Chair has a second or casting vote.

5.3 Members of the board have a collective responsibility for its operation, recognising that the success of the board will depend upon relationships and an environment of integrity, trust, collaboration and innovation. Members will participate in discussion, review information and provide objective input to the best of their knowledge and ability, and endeavor to reach a collective view.

6. CONFLICT OF INTEREST

6.1 Individual members of the group are accountable to their respective organisations/boards. Members of the Board will be asked at each meeting to declare any conflicts of interest for any items of business for that meeting.

7. QUORUM

7.1 The quorum will be three members to include both a member from the CCG and a member from the Council who is not the Single Accountable Officer.

8. SUB-GROUPS AND PROGRAMME GOVERNANCE

8.1 The Board will receive reports from the T&G ICS Working Group and programme-specific sub-groups, which will include as minimum:

- Finance and contracting
- Communications and engagement

- Workforce and organisational development
- Statutory functions
- Provider Collaborative.

9. FREQUENCY OF MEETINGS

9.1 The ICTB will meet monthly until March 2022 at the beginning of each T&G Strategic Commissioning Board.

9.2 The meetings of the ICTB will be held in private.