

Section 1: Background & Context

Evolution of National Policy

1. There is a long-recognised need for health and care services to be better integrated to improve people's care. The NHS Long Term Plan reinforced this direction of travel and noted an intention to 'dissolve the historic divide between primary community and acute health services' and further stated: 'The NHS will be more joined-up and coordinated in its care. Breaking down traditional barriers between care institutions, teams and funding streams so as to support the increasing number of people with long-term health conditions, rather than viewing each encounter with the health service as a single, unconnected 'episode' of care'.
2. The NHS Long Term Plan sets out the centrality of integrated care systems (ICSs) to achieving this goal and the importance of provider partnerships in delivering such care.
3. For this reason, commissioners and providers across the BOB geography have long been of the view that closer integration of sectors, services and organisations is desirable. Most of this work has occurred at a Place level to date, with Wave 1 ICS' in Berkshire West and Buckinghamshire. To facilitate this way of working, contractual forms and non-statutory governance have been developed which enable a greater focus on collaboration between partners.
4. The NHS Long Term Plan (LTP) published at the beginning of 2019, set out the vision and ambition for the NHS for the next 10 years. It builds on much of the success that has been achieved to date in the early Wave One Integrated Care Systems (now Integrated Care Partnerships (ICPs)) and the BOB STP (now a Wave Three ICS).
5. The Long-Term Plan states that *"Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level... This will typically involve a single CCG for each ICS area. CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long-Term Plan implementation"* -- NHS Long Term Plan (2019) p29
6. As a result of this policy statement, the CCGs within the BOB ICS agreed to establish an 'Architecture Oversight Group' comprised of the CCG Chairs and Chief Officers, ICS Leaders and lay members from each Place. The Group is Chaired by the ICS Independent Chair and was established in order to co-ordinate the work in this area and design a proposal which reflects the areas of mutual agreement between the parties.
7. In September 2019, the Oversight Group agreed to run an 'engagement exercise' with a broad range of stakeholders, including patients and the public, to understand the extent of views which may exist around this proposed change. The purpose of this exercise was to ensure that any future proposals could be crafted which are informed by the views of local people and partner organisations.

Methodology of the Engagement Exercise

8. On 10th October 2019, the three CCGs published a document titled *"The future arrangements for NHS commissioning in your area"* and commenced a period of engagement lasting until the 1st December

2019. This exercise was not a formal public consultation but rather an opportunity to hold an open dialogue with a broad array of stakeholders.

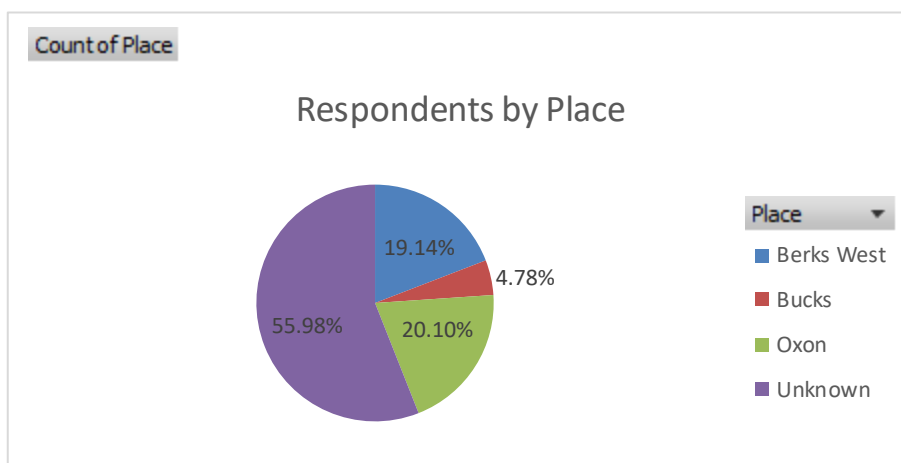
9. The engagement exercise sought the views of all stakeholders on the following three proposals:
 - a. The appointment of a single Accountable Officer and Shared Management Team for the three CCGs
 - b. The design principles for the creation of stronger Integrated Care Partnerships for each of the three places
 - c. The creation of a single commissioning organisation across the BOB geography (i.e. a merger of the three existing CCGs)
10. Respondents were asked to consider how each of the three proposals would contribute to five distinct drivers:
 - a. Meeting the ask of the NHS Long Term Plan, both with regard to the statements which relate to 'more streamlined commissioning' and the delivery of new integrated models of care to improve patient services.
 - b. Ensuring that the operating model and leadership aligns with an emerging approach to more collaborative commissioning
 - c. Supporting the newly formed Primary Care Networks more effectively and consistently
 - d. Providing a greater level of oversight and accountability for the Integrated Care System
 - e. Taking advantages of the new opportunities arising to share expertise and resources between organisations
11. Views on the proposals set out in the engagement document were invited through an online survey which was open to anyone to respond through. Respondents were also invited to make more detailed written submissions to either the ICS Office or their local CCG.
12. Buckinghamshire, Oxfordshire and Berkshire West CCG each pro-actively marketed the exercise to the public and key stakeholders within their respective areas to ensure stakeholders were aware of the engagement activity and had the fullest opportunity to respond. To support this work, the Architecture Oversight Group agreed an overarching communications and engagement plan which could be tailored for each of the local areas.
13. Channels used to promote the survey included: public newsletters, staff newsletters and correspondence with MPs. The survey was also highlighted on each CCG website, the BOB ICS website, and was circulated on social media. The CCGs also discussed the proposals, the engagement process and the survey at local meetings of stakeholders including Health and Wellbeing Boards, meetings with Healthwatches, and Patient Participation Groups.

14. The number of responses received was unexpectedly high for a set of proposals which are entirely about making changes to structures and management rather than the design of health or care services. 224 responses were received, which ranged between brief answers and multiple pages of feedback on the emerging principles of the proposals. Of these 224 responses, 209 were “countable” – 15 responses were either blank or contained information which could not be categorised consistently.
15. It should be noted that a number of responses received were critical of the overall style of the engagement document. This criticism was mostly focused on the prevalence of NHS ‘jargon’ and the lack of public friendly language in the engagement document.

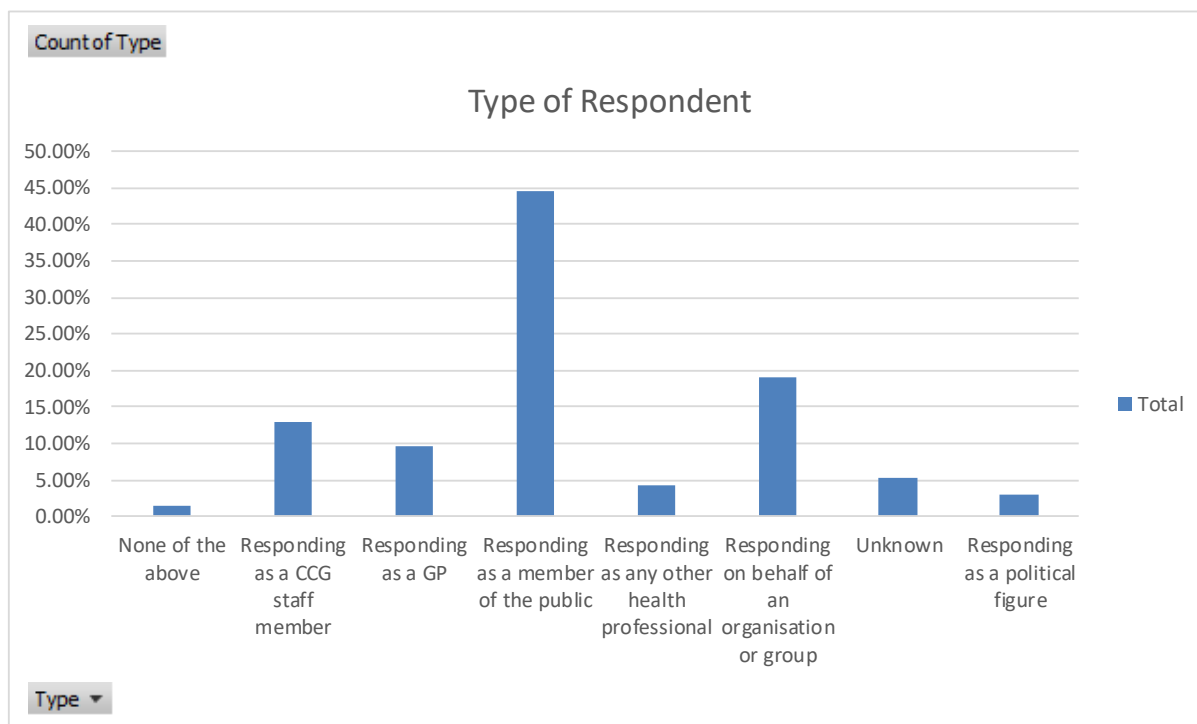
Section 2: Outputs of the Engagement Exercise

Collation of Responses Quantitative Analysis

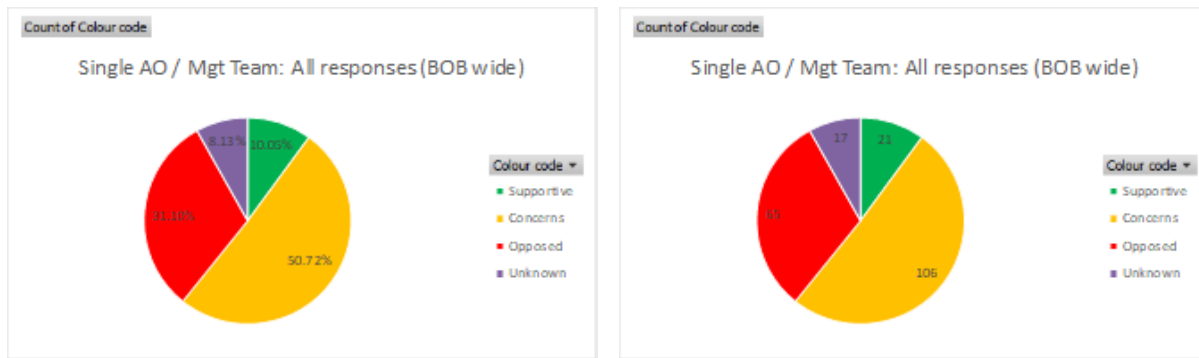
16. Every response submitted during the engagement period has been reviewed and categorised. Responses were reviewed for their qualitative view and categorised by place, type of respondent and level of support for the proposals.
17. There are therefore two main products of this review. One, a quantitative analysis, which seeks to demonstrate numerically how the responses can be broadly categorised. Secondly, a thematic analysis is presented which builds on the qualitative elements of the responses received. The thematic analysis is broken out by the three proposals which are made in the engagement document.
18. The following quantitative analysis focuses on two distinct areas; firstly, a more detailed breakdown of the type and location of the respondents; secondly, an indication of the level of support for the proposal to move to a single Accountable Officer and shared management team.
19. The initial charts presented provide further information on the number of respondents, their categorisation and their location. Respondents were not required to declare a place as a mandatory field on the online response form as it was felt that a material number of potential individuals / organisations may have an interest in more than one of the three places or would not necessarily wish to declare this information. As a result, more than half of the responses received could not be attributed to any single place from the geography. From the remaining responses, the majority were received from Oxfordshire and Berkshire West, with a minority of identifiable submissions coming from the Buckinghamshire area.



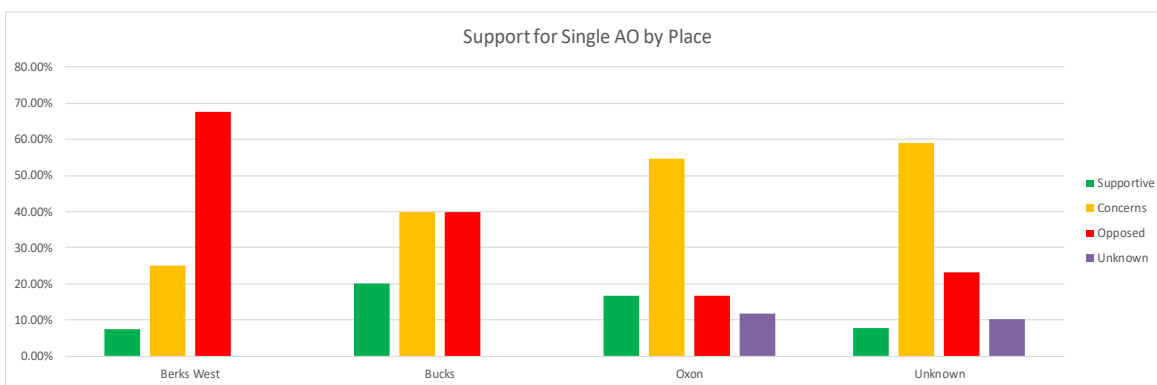
20. Respondents were also invited to share the basis on which they were responding to the engagement exercise. In this instance, most chose to disclose this information which is summarised in the chart below:



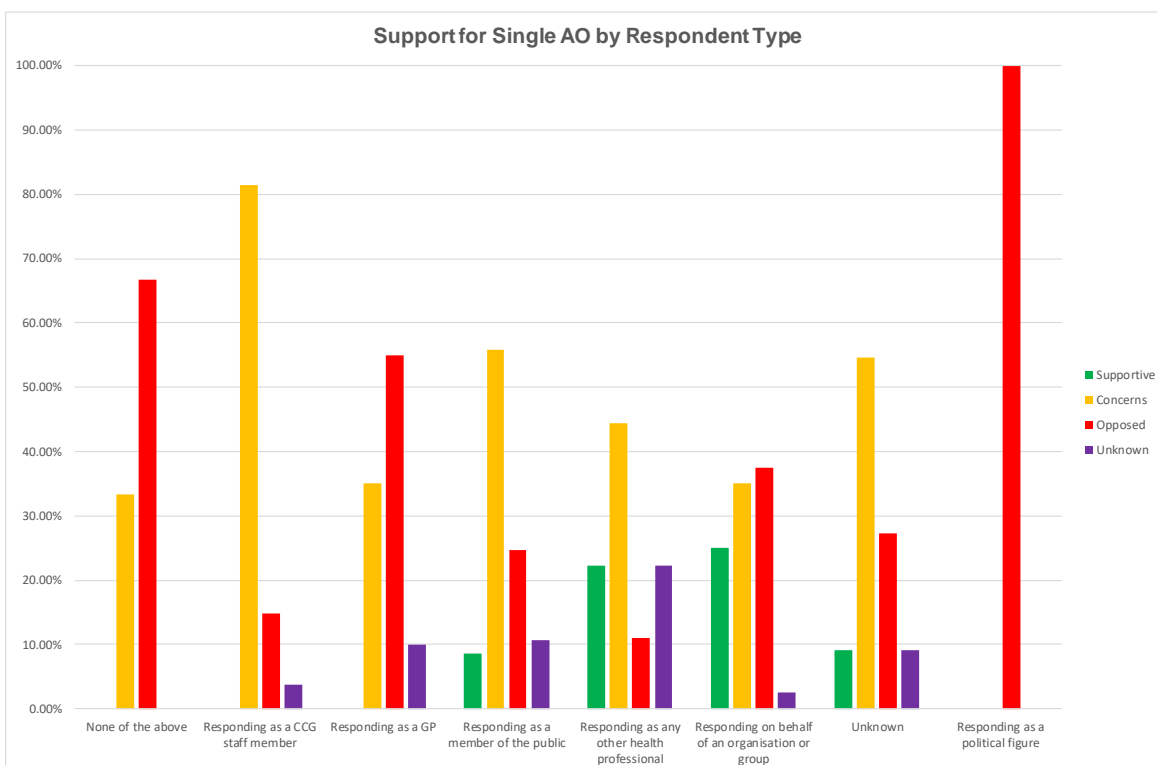
21. The vast majority of the responses received were from members of the public (93) which represents almost 45% of the total number of responses received. Caution should be applied to the category “Responding as a GP” which is artificially low in the dataset provided. This can be explained by a large number of responses which were received either from a Primary Care Network or a GP Practice and thus categorised as “Responding on behalf of an organisation or group”.
22. Respondents were not asked to state whether they were definitively supportive or not of the proposals contained within the engagement document. The intention of the exercise was to gain a greater understanding of the discursive views of stakeholders rather than simple binary responses. This is captured in greater detail in the following section on thematic analyses.
23. It was felt however that CCG Governing Bodies would find some kind of data analysis helpful to gauge the level of support for the proposals and this is presented below. Following a review of each response, their broad level of support was interpreted from the answers provided. These were separated into four categories – (i) Supportive, (ii) Concerns or Conditions Raised, (iii) Opposed and (iv) Unknown.
24. Whilst it should be noted that the intention is to provide an overview of the responses received, members should be aware that much of the data and subsequent themes will read as concerns raised by stakeholders. This is attributed to the nature of the engagement document which contained only outline proposals on the proposed changes, without being able to adequately describe a future state which may have been able to provide reassurance to respondents.
25. At a BOB level, the responses were categorised as follows:



Further analysis of these responses was undertaken and then quantified by the place identified by the respondent as follows:



26. Finally, the level of support was quantified by the type of respondent to the engagement exercise:



27. All of these data are summarised in the table below for reference:

Support for Single AO by Place & Respondent Type Breakdown	Support	Concerns	Opposed	Unknown	Grand Total
	Supportive				
Berks West	3	10	27		40
None of the above		1	1		2
Responding as a CCG staff member		4	1		5
Responding as a GP			3		3
Responding as a member of the public	1	2	6		9
Responding on behalf of an organisation or group	1	2	13		16
Unknown	1	1	1		3
Responding as a political figure			2		2
Bucks	2	4	4		10
Responding as a CCG staff member		1			1
Responding on behalf of an organisation or group	2	3	2		7
Responding as a political figure			2		2
Oxon	7	23	7	5	42
Responding as a GP		4	2	2	8
Responding as a member of the public	3	11	3	2	19
Responding as any other health professional	1				1
Responding on behalf of an organisation or group	3	6			9
Unknown		2	1	1	4
Responding as a political figure			1		1
Unknown	9	69	27	12	117
None of the above			1		1
Responding as a CCG staff member		17	3	1	21
Responding as a GP		3	6		9
Responding as a member of the public	4	39	14	8	65
Responding as any other health professional	1	4	1	2	8
Responding on behalf of an organisation or group	4	3		1	8
Unknown		3	1		4
Responding as a political figure			1		1
Grand Total	21	106	65	17	209

28. In summary, the quantitative analysis shows neither strong support nor outright rejection of the proposal. The majority of stakeholders qualified their responses with views which they believed were important to be addressed in the design or implementation of this proposal and further exploration of this is provided in the thematic review which follows.

29. A significant learning point from this engagement exercise is the difficulty in being able to effectively gauge the views of a broad range of stakeholders at a point prior to being able to accurately describe a model of future operation.

Qualitative / Thematic Analysis

Proposal One: The appointment of a single Accountable Officer and Shared Management Team for the three CCGs

Theme 1: Process for design, decision making and implementation

30. A number of consistent messages were present in this theme, noting a strong demand for a transparent decision-making process which took into account the views of local people and their elected decision makers. Some partner organisations went further than this, requesting an appointment process which ensured the identification of a candidate who has the support of all system partners.
31. Another overwhelming feature of the responses within this theme was a concern regarding the financial implications of the proposed change. This will be further expanded upon within the emerging themes of Proposal Three as this is not strictly altered by the appointment of a single Accountable Officer.
32. Finally, a further important conclusion of this theme was a request that there is a clear understanding and presentation of the benefits arising from this proposal. A general theme of the responses in this area included negative descriptors such as “outdated”, “American” and “complex”.

Theme 2: Link to local populations and their democratic oversight

33. Some of the strongest feedback with regard to this proposal came within the context of a loss of local influence, control and oversight of the CCGs and their leadership. This theme will also be explored further in the proposal on a single merged CCG. Nevertheless, even with regard only to the single Accountable Officer element of the proposal, this message was clearly expressed. Most broadly, there was significant and repeated concern that the centralisation of the Accountable Officer role would dilute local decision making, erode local knowledge of the Place based systems and potentially compromise the leadership of the local ICPs.
34. All of the responses received from Local Authorities were concerned that the proposal would weaken the link between local NHS leadership and the ability of democratically-elected Local Government organisations to hold the NHS to account through the established legal structures.
35. In mitigation of the above concerns, some responses accepted that this was a likely development in the evolution of NHS organisational structure and leadership. These responses made suggestions which were felt could temper any negative effects, such as maintaining links with ‘locality groupings’ of patients and ensuring senior appointments at a Place level which could continue to discharge certain important commissioning functions.

Theme 3: Deliverability of the shared Accountable Officer role at a larger scale

36. This question provoked a broad range of responses which are more difficult to group into a coherent set of sub-themes for consideration. There were, however, some areas of common alignment which are best summarised as follows and should be read within the context of the *status quo* whereby the Accountable Officer for Oxfordshire and Buckinghamshire CCGs is already shared between those two organisations.

37. Unsurprisingly, there was broad support for the appointment of an individual with a strong level of experience, support, authority and accountability. A number of responses specified a desire to see this individual supported by a strong management team and a formally appointed Deputy Accountable Officer. Some responses proposed that the NHS should consider a range of backgrounds from which to appoint this individual, including non-healthcare related private industry, the military and the NHS provider sector.
38. A significant number of the respondents objected to the creation of this role at a larger scale with some concern that the task will be undeliverable. Further to this, the desirability of the Accountable Officer being combined with the ICS Lead position was questioned by some partner organisations which felt that this may not be advantageous or possible to discharge the requirements of the role effectively.

Theme 4: Operation and effectiveness of a shared management team

39. Many of the responses received were clear in their desire to see a single management team which was equally representative of the three Places which form the broader ICS geography.
40. Similarly, a number of respondents stated that the size of the team should be minimised so as to reduce bureaucracy and cost in order to redirect resources to the “front line”. The desire to see a “lean” and “streamlined” management structure was a consistent theme of the feedback although the motivation of this change was questioned by some respondents who conjectured that this proposal was driven by a desire to reduce costs.
41. Finally, a significant number of the feedback responses expressed concern for the potential risk of losing staff during any potential period of uncertainty leading to and following on from any change to the current management team arrangements. This was felt to be a risk due to the potential for the loss of established positive relationships, local knowledge, desirable skills and an overarching difficulty to recruit staff within this region.

Proposal Two: The design principles for the creation of stronger Integrated Care Partnerships for each of the three places

Theme 1: A voice for local people in the design and decision-making processes

42. Respondents were broadly positive around the creation of local Integrated Care Partnerships and the overarching objective of improving the provision of more joined up services in their local places.
43. The request for greater involvement was a consistent theme of the responses to this proposal and this was a view expressed by members of the public and primary care practitioners most commonly.
44. Unsurprisingly, the role of clinicians in local service design and decision making was a strong feature of the feedback. This was expressed both with regard to the emerging role and influence of Primary Care Networks and also building on the experience of the CCGs to date in their role as drivers of service transformation.

Theme 2: Ensuring that ICPs are subject to Accountability and Transparency

45. A number of respondents were keen to ensure that as ICPs develop they are transparent with their stakeholders on both ways of working and overall intentions of the endeavour.
46. There was a significant level of request for Local Authorities to play a central role in the development and scrutiny of ICPs. Many respondents saw the opportunity which now exists for social care to become an ever-closer partner of the NHS, both with regard to the planning and funding of services but also through the provision of care at the 'front line'.
47. Central to much of the feedback received in this area was the importance of maintaining and continuing to evolve the relationships between leaders and staff of the multiple organisations involved with the development and delivery of ICPs.

Theme 3: Enabling ICPs to meet their objectives and deliver more integrated, joined up care provision

48. The most common theme of responses to this proposal was around the actual delivery of new models of care and how the experience of patients and the wider public may be improved through the opportunities of ICP development.
49. Respondents made a number of suggestions on how ICPs could be most successful and these tended to be focused on attributes such as flexibility, agility, being co-operative in their operation and the closest possible working between the NHS and social care providers.
50. Some respondents referenced the need for 'fair' budgetary allocations which would enable the ICPs to meet their objectives. There was some reference to a greater pooling of resources between the NHS and Local Government organisations to facilitate the implementation of this new way of working.

Proposal Three: The creation of a single commissioning organisation across the BOB geography

Theme 1: Ensuring that existing Place based systems are not financially disadvantaged by the creation of a single CCG with its own allocation

51. One of the most common responses received across all of the proposals related to a concern on the loss of financial resources from any given Place. There is a strong perception that should any of the proposals be adopted, money which is currently allocated for any of the three places will either be aggregated into a non-place specific pool or used to improve the financial position of a different part of the geography.
52. Most commonly there was an assertion that money from either Oxfordshire or Berkshire West would be used to support the Buckinghamshire health economy but other concerns were raised.
53. It is important to note that this thematic response was consistent regardless of the type of stakeholder. This view was as likely to be expressed from members of the public as it was to have been stated by professional stakeholders such as NHS provider organisations.

Theme 2: Protecting the interface between Local Authorities and their counterpart NHS Commissioning organisations

54. In common with the proposal around a shared Accountable Officer, the responses received from Local Authorities were concerned that the proposal would erode the interface between the statutory commissioning organisations and the corresponding Local Government organisation.
55. Some respondents felt that the complexities of working with numerous organisations, including Local Authorities, to transform systems would be made more difficult and complex both with regard to gaining consensus and effective decision making should the CCG be consolidated to a BOB ICS scale.
56. As well as the potential loss of the partnership benefits which arise from smaller, more co-terminus CCGs with Local Authorities, there was also concern expressed around the ability of numerous Local Government organisations to effectively scrutinise and hold to account a single CCG of a much larger size.

Theme 3: Loss of the 'local voice' within a larger commissioning organisation

57. Many of the respondents to the engagement exercise expressed concern that the views of local patients and populations would be more difficult to be taken into account if the boundary of the CCG moved to a larger scale. This was a consistent theme of feedback from members of the public but also from General Practice, the latter of which made a number of representations either at individual, practice or Network level.
58. For General Practice, this concern was often expressed through two different perspectives. Firstly, that the now well-established principle of clinical commissioning would be diluted if there were fewer place-based GPs represented in the decision-making structures of any new body. Secondly, there was further concern expressed that the 'voice' of local primary care would be lost within a larger organisation and that specific local issues around the sustainability and future development of primary care provision would be marginalised if not kept on its current local footing.

Theme 4: The BOB boundary being an 'un-natural' grouping of three very different geographies

59. Finally, some of the responses received questioned why the geography for a larger commissioning organisation had been set as per the proposal in the engagement document.
60. These respondents raised an issue which has been discussed a number of times previously with both partner organisations and wider stakeholders, namely that the BOB geography is an 'un-natural' grouping and does not reflect any kind of significant historic collaboration between these Places.

Section 3: Proposed amendments to the proposal resulting from stakeholder feedback

Single Management Team Design Principles

61. Implicit in the proposal for a single Accountable Officer across the three CCGs is the requirement for a shared management team to also operate at this level, reporting to the Accountable Officer and taking responsibility for functions across the larger geography.
62. Using the engagement document as a basis from which there is alignment between the organisations, the following principles are proposed from which a draft management team structure can be defined:

The Shared Accountable Officer will:

- a. Have individual accountability which mirrors our new ways of working
- b. Provide strong and consistent leadership across the commissioning organisation(s)
- c. Be able to establish a shared resource with significant expertise able to work at scale
- d. Achieve a greater level of efficiency for the taxpayer, patients and partner organisations

Each of the three Places will:

- e. Operate within a locally designed governance framework which binds the partners
- f. Have access to expert resource to ensure local delivery
- g. Have its own senior leadership which is represented at ICS level

The BOB ICS will:

- h. Offer ongoing support to place based organisations with opportunity analysis and the spread of best practice
- i. Act as the main point of assurance of places and place-based organisations
- j. Deliver savings which can only be achieved at ICS scale or across multiple organisations

63. Following the themes identified from the review of stakeholder engagement, it is proposed that the following principles should be adopted to address the views expressed:
- k. A link to local places, their populations and democratic structures
 - l. Need for a strong management team that can support large scale working
 - m. Reduction in bureaucracy and improvement in streamlined working
 - n. Support for ICPs and a strong link back to the CCG(s) / ICS Structure
 - o. The need to combine the ICS / AO role to provide statutory accountability
 - p. Development of a supporting clinical infrastructure to meet requirements

Single Management Team – Proposed features for adoption

64. Should the Governing Body decide to proceed with a proposal to establish a single management team, work will commence to design a structure which is consistent with the design principles presented above.
65. Whilst this design exercise will require some flexibility in order to ensure that the requirements of the organisations and their stakeholders are met, it is proposed that the following features of any new management team are a mandatory consideration:
- a. Continued adherence to current statutory requirements of the Health and Social Care Act to retain a Chief Officer, Chief Finance Officer and Nurse Director.
 - b. A dedicated member of the Management Team for each of the three places, most probably taking the form of a “Managing Director” role whose primary focus is their place and reports directly to the Chief Officer.
 - c. The retention of certain management responsibilities and functions at a Place level, under the day-to-day responsibility of the place-based Managing Director including (but not limited to): ICP Development, Primary & Community Care, contracting with local health and social care providers, design and delivery of pathway improvements, operational planning and joint commissioning with Local Authorities.

- d. The creation of new Director level posts to operate on a BOB ICS geography where more strategic / larger scale work would be of benefit and a supporting clinical structure which reinforces the clinical leadership of the CCGs.

Next Steps

66. This document has provided a summary of the process to date, the outputs of the engagement exercise, the management implications of moving to a single Accountable Officer and the proposed changes to the design of this proposal resulting from the responses to the engagement exercise.
67. The engagement document set out three distinct proposals for stakeholders to consider and comment upon. Governing Bodies are not yet required to consider taking a decision on proposals two and three (design of ICPs and a potential CCG merger) which will be re-examined during financial year 2020/21.
68. This approach therefore leaves only one proposal on which a decision is now required; the appointment of a shared Accountable Officer for all three of the CCGs within the BOB geography.
69. Based on the information and recommendations contained within this paper (see below) the Governing Body is now considered to be in a position whereby it can take a decision on progressing this proposal.

Recommendations

- (1) **NOTE** this paper and receive the report of the engagement exercise as a formal conclusion to the engagement period.
- (2) **AGREE** to commence the process for appointing a shared Accountable Officer for each of the three CCGs.

Should the Governing Body agree recommendations (1) and (2), it is also asked to consider the following:

- (3) **AGREE** the design principles (a-p) as a basis from which a proposal for a single management team can be produced.
- (4) **AGREE** the proposed mandatory roles and functions of any future management team structure to be incorporated.

Section 3: List of Appendices

Appendix 1: Table of mitigating actions in response to themes identified from engagement report

Appendix 2: Summary of local engagement activities during the engagement period

Appendix 3: Proposed Job Description for single Accountable Officer role