OXFORDSHIRE COUNTY COUNCIL

Oxfordshire Joint Health Overview & Scrutiny Committee
Friday, 2 August 2024

ADDENDA

5. Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board proposed new structure and operating model (Pages 1 - 42)

Nick Broughton (Chief Executive BOB Integrated Care Board) and supporting ICB officers have been invited to attend this meeting to discuss the BOB Integrated Care Board proposed new structure and operating model.

It is recommended that the Committee **AGREES** on:

1.Whether or not the proposed restructure constitutes a substantial change.

2. How the Committee should proceed in light of the proposed restructure.

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Divisions Affected – All

OXFORDSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

02 August 2024

Consideration of the Response to Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board Restructuring Proposals

Report by Director of Law and Governance

RECOMMENDATION

1. **The Committee is recommended to AGREE: -**

   1.1 Whether or not the proposed restructure constitutes a substantial change.

   1.2 How the Committee should proceed in light of the proposed restructure.

Executive Summary

2. Integrated Care Boards (ICBs) nationally were asked by NHS England to reduce their administrative costs by 30 per cent, with at least 20% to be delivered in 2024/25. The local ICB, Buckinghamshire, Oxfordshire and Berkshire West ICB (BOB ICB) have developed a series of proposals in response to this ask, reviewing its operating model at the same time as seeking to reduce its administrative costs.

3. These proposals include the removal of Place-based directors, supporting a move towards a more centralised approach to the ICB's activity. In view of the integrated working between the Council and health partners at a Place level, a change towards a more centralised approach by the ICB raises important questions as to how they will be impacted, for the consequences could be highly significant. Oxfordshire County Council officers have raised concerns over how integrated systems between the Council and NHS partners at Place-level, such as jointly-funded posts, pooled budgets and joint-commissioning arrangements could be impacted as they would be expected to undergo significant change under the new ICB's proposed new operating model.

4. Following a private meeting with senior BOB ICB and Oxfordshire County Council officers, the Committee has called an additional, public meeting of the Committee to consider, under its powers within The Local Authority (Public

Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 ('the Regulations') to consider the proposals and potentially escalate concerns to the Secretary of State. This paper seeks to advise members on their rights concerning any decision to write to the Secretary of State requesting the matter be called in, in readiness to make any decision on whether to do so.

Background

5. A timeline of the key events which have happened to date are included below:

29 April 2024	BOB ICB launches a consultation with its staff on a proposed new structure and operating model.
11 July 2024	BOB ICB sends Oxfordshire County Council an e mail containing a presentation (found in Annex 1), requesting feedback on it by 04 August.
19 July 2024	HOSC Substantial Change Toolkit requested from BOB ICB
22 July 2024	Further request for the HOSC Substantial Change Toolkit requested
23 July 2024	BOB ICB sends further information to Oxfordshire County Council – a Partner Briefing paper (found in Annex 2) and a more detailed breakdown of proposals (not provided to HOSC and not published).
25 July 2024	An informal meeting is held between HOSC members and key officers from BOB ICB and Oxfordshire County Council to determine whether a formal meeting is required.
25 July 2024	An extra meeting of the Oxfordshire HOSC is called to consider the proposals.

6. A number of pertinent dates are missing from the timeline above on the basis that the details are not known. These include:

   (a) When the ICB began developing the proposals
   (b) When, or if, the proposals were discussed at the Place Based Partnership
   (c) When, or if, other Councils and other stakeholders were informed of the proposals
   (d) When the ICB made its decision to 'move into turnaround'[1] and when it informed NHS England of its intention to do so.

7. The ICB informed the Chief Executive of Oxfordshire County Council of its proposed restructure by e mail on 11 July 2024, and with further information shared on 23 July 2024. The Committee is in receipt of two of the three items shared (Annexes 1 and 2), but the ICB declined on request to provide the third item to members of the HOSC.

[1] Annex 2 para 3

8. Having been informed, the Council, via the HOSC, under s. 23 (4) of the Regulations 'may make comments on the proposal consulted on by the date or changed date provided by R under paragraph (1)(b)(ii) or (c)'. The Committee is invited to determine the category of change the proposals represent, and consequently the level of attendant involvement in the process it would expect to have had, as well as that of other key stakeholders.

1. What Constitutes a 'Substantial Change'?

9. The following advice on what constitutes a substantial change is taken from the Oxfordshire HOSC and health provider protocol:

"Whether a development or variation is substantial is not precisely defined and judgement is required. The impact of the change on patients, carers and the public is the key concern. The following factors should be taken into account:

The following describes and gives examples of the levels of change, variation or development

• The number and vulnerability of the people affected by the proposed change.
• Changes in accessibility of services (both in terms of location and quantity of service available) such as reductions, increases, relocations or withdrawals of service.
• Impact on the wider community and other services such as transport and regeneration and economic impact
• Impact on patients – the extent to which groups of patients are affected by a proposed change.
• Methods of service delivery – altering the way a service is delivered. The views of patients and Healthwatch are essential in such cases."

10. The protocol provides examples of what would and would not be deemed to be a substantial change (overleaf).

Level	Category	Description	Example(s)	Action Required
1	Minor	When the proposed change is **minor** in nature	A change in clinic times, the skill mix of particular teams, or small changes in operational policies.	Committee would not routinely be notified or become involved.
2	Moderate	Where the proposed change has moderate impact or consultation has already taken place on a national basis	Rationalising or reconfiguring Community Health Teams. Policies that will have a direct impact on service users and carers, such as the "smoke free" policy. This does not include where there is: • Reduction in service • Change to local access to service • Large numbers of patients being affected	The responsible commission notifies the HOSC Planning Group at an early stage. HOSC Planning Group determine whether a fuller briefing is required in accordance with the Committee's stage one assessment process described below. The Committee will wish to ensure that the Healthwatch and other appropriate organisations are notified by the responsible commissioner or service provider concerned.
3	Substantial	Where the proposal has substantial impact and is likely to lead to • Reduction or cessation of service • Relocation of service • Changes in accessibility criteria • Local debate and concern	Major review of service delivery, reconfiguration of GP Practices leading to practice closures, or the closure of a particular unit.	• The responsible commissioner(s) notify the Committee and formally consult the Committee. The Committee will expect to see formal consultation plans. The Local Ward Councillors concerned will be informed of the proposal. • The responsible commissioner(s) notify and discuss with the appropriate local authorities on service developments. • The responsible commissioner(s) follow the NHS duty to consult patients and the public. • The Committee consider the proposal formally at one of their meetings. • Officers of the responsible commissioners and service providers work closely with the Committee during the formal consultation period. • The Committee responds within the time-scale specified by the responsible commissioners. If the Committee does not support the proposals or has concerns about the adequacy of consultation it should provide reasons and evidence.

11. For the HOSC to determine that a proposal is a substantial change does not require the agreement of the healthcare provider.

12. When making its decisions over whether a change should be considered a substantial one, it is customary practice for the Committee to be provided with a Substantial Change Toolkit, filled in by the organisation making the proposed changes. The ICB was requested to complete the form on two occasions, but did not do so. The Committee is nevertheless advised to use section B of the pro forma Substantial Change Toolkit (Annex 3) as a guide to reaching its decision.

13. Under its powers in 23 (9) of the Regulations, the Committee must make a decision over whether the consultation on the proposals has been adequate in time or scope, and/or whether it believes the proposals would be in the interests of the health service in Oxfordshire. The threshold for determining adequacy relates to the category of change the proposals are adjudged to be, as detailed in the table above. Under this power, it may also write to the Secretary of State requesting that the proposals be called-in.

14. The Committee is strongly advised not to contact the Secretary of State unless it believes the change to be 'substantial.' Centre for Governance and Scrutiny (CfGS) advice, however, does not explicitly preclude writing to the Secretary of State for lesser changes:

    "A call-in request can be made about any proposal, not just ones that relate to notifiable reconfigurations. A HOSC (or any other person) could make a request on the basis that they consider that a change is notifiable, and (for example) that the consultation planned for that proposal is inadequate."

15. It should be noted that if the Committee were to write to the Secretary of State, recent changes to the Regulations[2] would mean that the old, automatic power of referral to the Secretary of State for consideration no longer exists. Instead, the Committee may only request that the Secretary of State call the matter in, a decision which is at the Secretary of State's discretion.

16. CfGS guidance on referral powers state that "The Statutory guidance does not specify any timeframes. As long as a proposal for reconfiguration exists, a request may be made at any point in the reconfiguration process. However, local attempts to resolve the issue must have been exhausted before this happens." Should it wish, therefore, to contact the Secretary of State it need not do so during the consultation period. It is advised that the Committee is assured that all efforts to reach a local resolution have been exhausted beforehand.

17. The Committee should be aware that if it wishes to make a response to the ICB consultation, it should do so by the closing date of 04 August 2024.

[2] Enacted by the Health and Care Act 2022, and enacted on 31st January 2024

Corporate Priorities

18. Improving health and wellbeing of residents and reducing health inequalities are stated ambitions within the Council's Strategic Plan.

Legal Implications

Requirements for Notification Regarding a Substantial Change

19. Under The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 providers of health services have a responsibility to consult over substantial developments or variations to the provision of health services in an area. Regulation 23(1) states:

"where a responsible person ("R") has under consideration any proposal for a substantial development of the health service in the area of a local authority ("the authority"), or for a substantial variation in the provision of such service, R must—

(a) consult the authority;

(b) when consulting, provide the authority with—

(i) the proposed date by which R intends to make a decision as to whether to proceed with the proposal; and

(ii) the date by which R requires the authority to provide any comments under paragraph (4);

(c) inform the authority of any change to the dates provided under paragraph (b; and

(d) publish those dates, including any change to those dates."

Secretary of State Call-In

20. Health Overview and Scrutiny Committees (referred to as 'the authority' here) have the power to write to the Secretary of State under Regulation 23 (9) in the following circumstances:

"The authority may report to the Secretary of State in writing where—

(a) the authority is not satisfied that consultation on any proposal has been adequate in relation to content or time allowed;

[…]

(c) the authority considers that the proposal would not be in the interests of the health service in its area."

Comments checked by: Anita Bradley

Anita Bradley, Director of Law and Governance and Monitoring Officer. anita.bradley@oxfordshire.gov.uk

Financial Implications

21. There are no direct financial implications arising from the recommendations in this report.

22. The financial implications of the ICB's restructuring proposals are presently unknown. There are likely to be impacts on local joint commissioning arrangements as well as the resourcing and activity arising from place-based coordination for social care and public health. However, further information is needed to be able to assess the impact on the council.

Comments checked by: Kathy Wilcox

Head of Corporate Finance and Deputy Section 151 Officer.
kathy.wilcox@oxfordshire.gov.uk

Staff Implications

23. None arising directly from this report, though the implications of the restructure could potentially have far-reaching staff implications for Oxfordshire County Council staff should structures around commissioning and Place-based coordination need to be significantly altered.

Equality & Inclusion Implications

24. None arising directly from this report, though the implications of the restructure are not yet fully understood.

Sustainability Implications

25. None arising directly from this report, though the implications of the restructure are not yet fully understood.

Risk Management

26. Requesting a call-in from the Secretary of State is a sign that a negotiated solution has proven impossible. Doing so is likely to have negative consequences on the working relationship between the Committee and ICB stakeholders. This is not a reason in itself to avoid making a referral when it is justified, but the implications of doing so must be weighed carefully when making that decision.

Anita Bradley
Director of Law and Governance and Monitoring Officer

Annex: 1. ICB Restructure Operating Model presentation
2. ICB Partner Briefing
3. Empty Substantial Change Toolkit

Background papers: None

Other Documents: None

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August 2024

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Our Operating Model

Transforming how we work

Leading the NHS locally, for fairness, sustainability & improvement

July 2024

Introduction

At Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) we are a statutory organisation, responsible for providing leadership of the NHS in our area. We do this by planning, funding and overseeing services for our population of 1.8 million people and making decisions about the best use of our £3.6bn budget to meet our residents' needs. Our Integrated Care Strategy and Joint Forward Plan set out our high-level ambition of how we want to do this.

Over the last few years, as our organisation has been established, we have been through a lot of change. This has created uncertainty and sometimes a lack of clarity as to our purpose, how we work and how we can best add value. We have therefore reviewed and refreshed our operating model so that we are able to:

- Focus on what we are **uniquely placed** to do as a system leadership organisation
- Deliver our core functions **effectively** and **efficiently**
- Build the right **culture and behaviours** to work well across our teams and in collaboration with our partners.

This pack sets out our thinking in response to these points and covers:

- **Our context** – about our system and the population we serve
- **Our purpose and role** – what we are uniquely placed to do and how we do it
- **Our teams** – how each of our teams add value
- **How we work** – developing our culture, values and processes
- **Next steps** – sharing your views

HAVE YOUR SAY

- We are interested to hear what you think about what we have set out here and any ideas you have about how we might improve how we work.
- Please visit page 20 for more information on how to share your views.

Our context: our population

Nearly 2 million people live and work across BOB. The health and care needs of our residents vary considerably, depending on circumstances, ability to access support when required and experience of using NHS services:

Inequalities

- **Life expectancy gap** of over **10 years** between least and most deprived areas
- 58,000 people live in areas in the **20% most deprived areas** nationally
- People in deprived areas within BOB develop poor health **10-15 years earlier**

Health conditions

- 12% of adults have **depression**
- 6 out of 10 people are **obese or overweight**
- It is estimated that **3 in 5** people over 60 years have a **long-term condition**

Demographics

- The number of people aged 65 and over will **increase by 1/3** in 10 years
- Nearly **1 in 5 people** are **over 65** years old and 1 in 4 people are under 19
- People from **ethnic minority groups** are more likely to live in deprived areas

Our context: our ICS partners

We are part of BOB Integrated Care System (BOB ICS) working together with partners to deliver our 4 shared aims:

- 8000+ voluntary organisations
- 150+ GP practices
- 5 Healthwatch organisations
- 5 universities
- 68,000 health and care staff
- 250 care homes
- 800+ schools
- 200+ dental practices
- 250+ pharmacies
- 3 acute/integrated hospital trusts
- 5 unitary/upper tier local authorities
- 2 mental health trusts
- 1 ambulance trust
- 5 district councils

1. **Improve outcomes** for our population health and healthcare
2. **Tackle inequalities** in outcomes, experience and access
3. Enhance **productivity** and **value for money**
4. Support broader **social and economic development**

Our context: our places

The majority of the health, care and other public and voluntary services people use are delivered within the community or 'places' where they live or work

- Our system is made up of three places, which are smaller geographies that align closely to **local authority** footprints and provide the foundation for much of our work on a larger scale.
- Each of our places has an established **place-based partnership** that collaborates across different organisational boundaries to integrate services based on people's needs.
- In addition to our teams who work at system level, we have an **ICB place-facing team** to support the development of our three place-based partnerships (see more on page 16).

Buckinghamshire

Oxfordshire

Berkshire West

Our context: provider collaboratives

Within our system, we have two provider collaboratives, focused on driving collaboration across our acute and mental health NHS trusts to deliver greater impact together:

Provider collaboratives are partnership arrangements between NHS Trusts focused on:

- Reducing **unwarranted variation** and **inequality**
- Ensuring **efficiencies** and **economies of scale**
- Improving the **resilience of services**, for example, through mutual aid

Acute Provider Collaborative

- Royal Berkshire NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust
- Buckinghamshire Healthcare NHS Trust

Mental Health Provider Collaborative

- Oxford Health NHS Foundation Trust
- Berkshire Healthcare NHS Foundation Trust

Provider collaboratives are a critical part of how we will continue to work together across our system to help us achieve the best outcomes for our patients and communities.

*Our mental health trusts are also members of other provider collaboratives that operate beyond the BOB ICB geography focused on the coordinated delivery of specialised services.

Our purpose and role

"Leading the NHS in Buckinghamshire, Oxfordshire and Berkshire West so that it is fairer, more sustainable & improves people's lives"

7 – BOB ICB: our operating model

ICB as system leader

Statutory responsibility to arrange health services for our population by setting direction, allocating the NHS budget, overseeing delivery and driving transformation and improvement.

ICB as delivery organisation

We arrange and manage certain services on behalf of the wider system, including All Age Continuing Care; Primary Care Operations; GP IT; Prescribing and High-Cost Drugs.

Running the ICB

Ensuring the smooth running of our organisation to support both our internal operations and how we discharge our statutory and system leadership functions e.g., our finance team.

How we work to deliver our purpose

Our purpose

We exist to:

"Lead the NHS in Buckinghamshire, Oxfordshire and Berkshire West so that it is **fairer, more sustainable** and **improves people's lives**"

Our role and functions

We deliver our purpose through:

Our **system leadership** role

Our **delivery** role

Running the ICB

Our teams

We are organised into:

Six directorates, each led by an Executive Director, reporting to the Chief Executive Officer.

Each team contributes to delivering our roles and enabling us to achieve our purpose.

- **Delivery, Performance & Oversight**
- **Finance**
- **Medical**
- **Nursing**
- **People**
- **Strategy, Digital & Transformation**

Delivery, Performance & Oversight

The Delivery, Performance & Oversight directorate is responsible for:

- **Oversight of provider operational performance** including delivery of constitutional standards.
- Partnership working with our three places through a dedicated **place-facing team.**
- ICB and **system resilience and emergency planning** to ensure robust and resilient responses to incidents or disruptive events.

Core Functions

- Performance, delivery and oversight of:
  - Community NHS and integrated services
  - Urgent and Emergency Care
  - Planned care
  - Mental Health, Community, Learning Disability & Autism and Special Education Needs and Disabilities
- Place partnerships and joint commissioning
- Emergency planning, preparedness and response (EPPR) and System Co-Coordination Centre (SCC)
- Thames Valley Cancer Alliance (hosting)

Delivery, Performance & Oversight

- Finance
- Medical
- Nursing
- People
- Strategy, Digital & Transformation

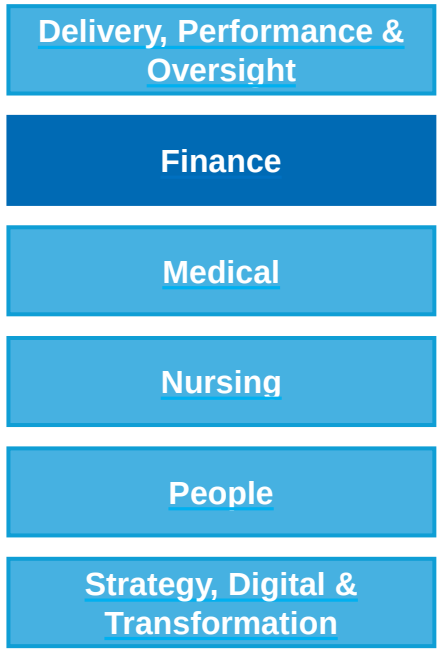
Finance

The Finance directorate is responsible for:

- Developing and reporting on **annual and long-term system financial plans** to support delivery of high-quality NHS services
- **Oversight, control and management** of system and ICB finances
- **Contract management and procurement** to ensure alignment with finance controls and value for money.
- System and ICB **capital planning**

Core Functions

- System financial strategy and planning, including long term planning, transformation and efficiencies
- Financial management for the ICB
- Finance business partnering – empowering budget holders and managers
- Management accounting and reporting for the ICB and reporting for the system
- Capital and estates planning and reporting
- Contracting and contract management
- Procurement



Medical

The Medical directorate is responsible for:

- Providing **medical clinical leadership** across the ICB.
- Delegated **commissioning of primary care** – GP services, community pharmacy, optometry and dentistry.
- **Clinical effectiveness** and Individual Funding Requests.
- **System-wide programmes** which include Medicines optimisation; health inequalities and Long-Term Conditions.

Core Functions

- Primary Care Operations
- Primary Care Transformation
- Primary Care Infrastructure & Pharmacy, Optometry & Dentistry (POD)
- Medicines Optimisation
- Clinical Effectiveness
- Health Inequalities & Prevention
- Long-Term Conditions (LTC) including LTC networks
- Medical clinical leadership

Delivery, Performance & Oversight

Finance

Medical

Nursing

People

Strategy, Digital & Transformation

Nursing

The Nursing directorate is responsible for:

- Providing **strategic and clinical leadership** to nursing and Allied Health Professional staff, ensuring that nursing practices are evidence-based and aligned with national standards.
- Overseeing the **quality and safety of care** across the system, implementing policies and procedures to maintain high standards and improve patient outcomes.
- Leadership and oversight of **All Age Continuing Care** (often known as CHC).
- Delivering ICB statutory duties on **children and adult safeguarding.**

Core Functions

- Safeguarding
- Women's and Children's services
- Quality – including Infection Prevention Control (IPC), Clinical Standards and Vaccinations
- Allied Health Professionals and Clinical Leadership
- All-Age Continuing Care
- Clinical Placements

Delivery, Performance & Oversight

Finance

Medical

Nursing

People

Strategy, Digital & Transformation

People

The People directorate is responsible for:

- **Employee Relations** - managing relationships with staff, including engagement, wellbeing, and addressing any employment issues.
- Developing and implementing **HR policies** that align with NHS standards and regulations.
- Providing **strategic workforce leadership** across the BOB system and guidance on how to shape the workforce to adapt to changing healthcare demands.
- Our People function is overseen by a shared Chief People Officer with Frimley ICB on an interim basis.

Core Functions

- ICB HR services and staff wellbeing
- ICB organisational development
- ICS workforce strategy and leadership
- Training and Education

- Delivery, Performance & Oversight
- Finance
- Medical
- Nursing
- **People**
- Strategy, Digital & Transformation

Strategy, Digital and Transformation

The Strategy, Digital and Transformation directorate is responsible for:

- **Strategic commissioning and system planning** to inform the allocation of resources.
- System **development and transformation** to create a more resilient and sustainable system.
- Leading delivery of system **digital, data and technology** strategy, managing digital / data services and providing digital support.
- Ensuring effective **governance** arrangements are in place for the running of the ICB.
- **Public involvement, communications and engagement** activities, working with system partners to inform and engage with our local population.

Core Functions

- Strategic commissioning and coordination of system planning (including specialised commissioning)
- System development, transformation and improvement
- ICS digital and data strategy, transformation and service delivery
- Governance
- Communications, engagement and public involvement

- Delivery, Performance & Oversight
- Finance
- Medical
- Nursing
- People
- **Strategy, Digital & Transformation**

How we work: aligning to deliver our purpose

- **Our purpose –** "Leading the NHS in BOB so that it is fairer, more sustainable and improves people's lives"
- **Our teams –** Organising our teams to deliver our core roles – system leader; delivery organisation & running the ICB
- **Our processes –** Developing effective and efficient processes to enable us to execute our roles and have an impact

- **Our culture –** Embedding our values in all we do: Respectful, Integrity, Collaborative, Leadership, Impactful
- **Working with our places –** Working in partnership with our three places, alongside our system work at scale across BOB
- **Learning and improving –** Working with our people, communities & partners to understand how we can improve to strengthen our impact

How we work: system & place

Place partnerships and Integrated Care Boards have defined and complementary roles, as set out in law & national guidance:

ICB [1]	Place partnerships [2]
• **Set direction** – agree a plan to meet population health needs. • **Allocate the NHS budget** – arrange the provision of healthcare services to secure improvements in population health, prevention, diagnosis and treatment of illness. • **Oversight and assurance** – first line oversight of provider performance. • **Drive transformation and improvement** – duty to secure continuous improvements in effectiveness, safety and quality of services.	• **Shared plan** – Work together to agree shared plans to address needs of local population. • **Coordinate delivery** – collaborate to improve health outcomes, prevent ill-health and reduce inequalities. • **Build partnerships** – bring together partners to meet the needs of local people and communities. • **Influence improvements** – in the wider determinants of health and social and economic development.

Buckinghamshire Oxfordshire Berkshire West

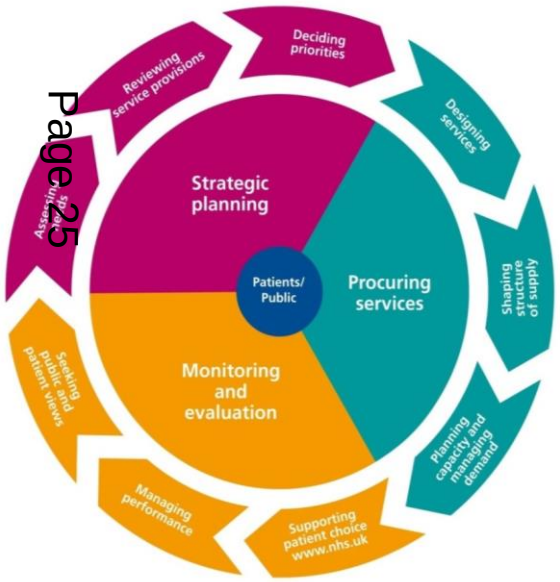
- Place partnerships are critical to the success of the ICB and our wider integrated care system.
- We want to increase the connection between our place teams and the wider ICB, so are creating a new Director level post to oversee and coordinate our place-based activities.
- This shift will support our teams to be both part of driving improvement at local neighbourhood and community level, whilst also supporting and better informing our ambition to tackle inequality at scale and improve outcomes across the system.

1. Health and Care Act 2022 & NHS England Operating Framework

2. Thriving Places Guidance

How we work: commissioning cycle

All our teams play an important role in helping us fulfil our statutory role of arranging healthcare service for our population:



Directorate	Strategic Planning	Procuring services	Monitoring & evaluation
Strategy, Digital & Transformation	• Gathers data, evidence and analysis to ensure insight-based commissioning • Sets overall direction and runs prioritisation and allocation process as part of annual and in-year planning	• Collaboratively designs the service and sets the specification	• Seeks public and patient views to inform service improvements
Delivery, Performance & Oversight	• Provides subject matter expertise on operational performance and delivery • Understands pathway specific challenges, provider capabilities and capacity	• Inputs to specification development and performance requirements • Feeds back on delivery opportunities and potential risks/constraints	• Coordinates provider interactions, oversight and assurance • Monitors and assures delivery of planning guidance and other related commitments
Finance	• Financial framework and analysis incl. impact of local controls • Support prioritisation process	• Lead on putting service design and specification in the relevant contract. • Technical liaison with providers	• Support delivery and integrated performance reporting (finance, performance and quality)
Nursing	• Oversight of service quality and safety; ensuring clinical standards are maintained and included in the commissioning detail where required; advising on service improvements; patient experience.		
Medical	• Subject matter expertise for the end-to-end planning and management of primary care service provision as per delegated commissioning arrangements (general medical, pharmacy, optometry and dental services)		
People	• Coordinating workforce planning for NHS service provision to support delivery of the strategic priorities. Plan developed collaboratively in the context of wider ICS workforce strategy.		

[1]NHS England commissioning cycle

How we work: our people and communities

As we implement our operating model, we will be strengthening our approach to working with our local people and communities, putting more dedicated resource and focus to support this aim:

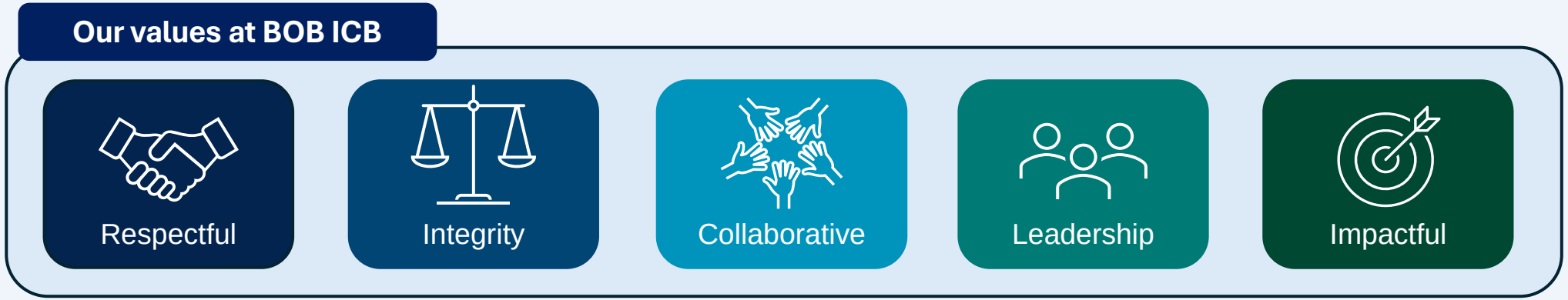
We will be guided by the principles in our engagement strategy:

- **Listen** – active listening to learn from the knowledge and experience of others.
- **Understanding** – continually build our understanding by reaching out to communities, inviting input and showing how that input contributes to our work.
- **Engaging** – ensure our engagement activity is always meaningful and tailored to the people and organisations we are engaging with.
- **Informing** – meaningful engagement can only take place when people are adequately informed.
- **Enabling & co-producing** – build and foster effective relationships to allow for genuine co-production wherever possible.
- **Embracing diversity, equality, and inclusion** - BOB ICB will champion diversity, equality, and inclusion and we will ensure that representation is visible. We will constructively challenge all partners to demonstrate progress in reducing inequalities and improving outcomes.

1. NHS England guidance on working with people and communities

How we work: our culture, values and behaviours

Our values were developed by our teams when the ICB was formed in 2022. As we implement our operating model, we will continue to develop our culture and behaviours, being clear about what our values look like in practice across all our teams and interactions.



Working with all our teams and staff networks, we will also continue to implement the **NHS People Promise** ensuring we are compassionate and inclusive, everyone feels they have a voice, we work as a team and are always learning and improving together.

Next steps: have your say

Whether you are a member of staff or one of our partners, we would love to hear your views on our operating model:

We are interested to hear your thoughts about how we are setting up the ICB and your ideas and suggestions on how we can further improve how we best work together.

Please share your views on how we should:

- Set up our new ways of working to **deliver our purpose**
- **Collaborate** more closely with our partners across our system
- Better **engage our communities** in our work

What will happen to your feedback
Our team will review your feedback and share themes and outcomes of what we have heard in September 2024.

Email directly to bobicb.opmodel@nhs.net

Arrange a meeting with the ICB by emailing bobicb.opmodel@nhs.net or calling 0300 123 4465

Thank you for reading our Operating Model
Please share your views with us at: bobicb.opmodel@nhs.net

Leading the NHS locally, for fairness, sustainability & improvement

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NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

BOB ICB Revised Operating Model – July 2024

Additional briefing on the changes we are proposing

Context:

1. On 29th April 2024, Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) launched staff consultation on a proposed new structure and operating model to meet the 30% running cost reduction target. It was proposed that this would be achieved through a reduction in the scale of the ICB functions and capabilities but with limited changes to ways of working.
2. During the consultation period with staff, we received significant feedback that the ICB's proposed operating model and ways of working were not clear and did not demonstrate how the ICB adds value across the BOB Integrated Care System. It also became apparent that some aspects of the merger to bring the three Clinical Commissioning Groups together had not been fully completed. As a result, some parts of the ICB are still working in historical ways rather than as one organisation, causing duplication, inefficiency and inequity.
3. In parallel with this feedback, the financial challenge facing the ICB became clearer and the ICB took the decision to move into turnaround. The ambition of the turnaround programme is to stabilise the ICB (governance, controls, operational and financial management, and stronger business processes) and then lead the NHS organisations across BOB to a position of operational and financial sustainability. NHS England were strongly supportive of the move into turnaround and further encouraged the ICB to focus on creating an organisation with the necessary capacity and capability to better respond to system priorities and support sustainability.
4. In response to these challenges, the ICB committed to review its core ways of working and ensure the alignment of our teams to the delivery of its core functions. We have aimed to ensure that we have the right capacity and capabilities to fulfil our statutory role of allocating the NHS budget and commissioning services for our population, paying due regard to our duties to reduce inequalities, improve health and services and ensure effective, economic and efficient use of our £3.6bn budget[1].
5. This briefing:
    - Outlines the more significant shifts in resources we are making and why we believe this will allow for more effective delivery of our core, statutory responsibilities.
    - Sets out the key changes for the Place and system model (with further detail in Appendix 1)
    - Reinstates our hope to meet with all partners to discuss how we best implement these proposals and move to a more sustainable and equitable system.

[1] Health and Care Act 2022 (legislation.gov.uk)

The ICB's revised operating model

6. The revised operating model describes the ICB's purpose as "*Leading the NHS in Buckinghamshire, Oxfordshire and Berkshire West so that it is fairer, more sustainable and improves people's lives."*

7. It proposes that the purpose will be delivered through three strategic roles:
    a. the ICB as a system leader
    b. the ICB as a delivery organisation
    c. running the ICB.

8. The changes in our revised operating model link closely with the need to ensure we have the right capacity and capabilities aligned to each of these roles. These proposals give greater strategic emphasis to the 'system' role of the ICB, strengthening our focus on how best to commission and transform the system to improve outcomes for the 1.8 million people who live and work across our geography.

The ICB as a system leader

9. The ICB must fulfil its primary duty to arrange health services for the population. This will be achieved through setting direction, planning and allocating the NHS budget, overseeing delivery and driving transformation and improvement.

    How is this reflected in the operating model?

    - *Strategic commissioning and planning* – A dedicated team will provide the capability to ensure we allocate our resources and commission services based on a robust understanding of our populations' needs, using data and evidence to help us tackle unwarranted variation, inequity in access, experience and outcome, improve performance and spread best practice. A newly formed team in the ICB will pool knowledge and experience from across our current teams. This team will also include the resource and capability to lead and coordinate system-wide NHS planning across our different providers. It will involve matrix working with the finance and contracting function, and with the delivery elements of the ICB.
    - *Performance* – The ICB has a responsibility for the performance and oversight of NHS services across BOB. To support this, the new operating model proposes a Performance and Delivery team, with subject matter experts leading the oversight of different service delivery areas.
    - *Transformation* – Given the need for ongoing improvement and reduced variation and inequity, our operating model proposes a small team to provide skilled support to lead and oversee change across BOB, with support from delivery teams.

The ICB as Delivery Organisation:

10. As an organisation, we have responsibility to arrange and manage certain services on behalf of the wider system, including All Age Continuing Care; Delegated commissioning of Primary Care; GP IT; Prescribing, and other statutory services (e.g. safeguarding).

How is this reflected in the operating model?

- *All Age Continuing Care (AACC)* – This £250m service is not sustainable in its current form and needs to be better planned and managed to reduce variation and inequities, demand and cost pressures. The revised operating model proposes a

more robust management for the AACC team which includes a Director-level appointment, more substantive clinical assessors (currently largely temporary) and a more substantial operational and financial enabling team. This is expected to reduce variation across our three Places, lead to a more sustainable model of service delivery and more consistent and effective ways of working with our partner organisations.

- *Digital, Data and Technology* – This function is proposed to join as a part of a newly consolidated directorate, the Strategy, Digital and Transformation directorate to align with system strategy and the delivery of system transformation and improvement.

Running the ICB

11. The ICB was formed through the merger of three Clinical Commissioning Groups – however, in some areas a fully integrated way of working is yet to be achieved. Our operating model aims to create a stronger and more consistent operating approach within the ICB, and how we work with our partners.

12. There is a need to revise operational and financial management and processes and controls in all areas to ensure that we consistently achieve best practice standards. There is also a short term need to more tightly grip all expenditure and ensure it is consistently aligned with what is necessary to deliver our core priorities and reduce inequity across the system.

How is this reflected in the operating model?

The core functional responsibilities of the Finance and Contracting Directorate need to be restructured to focus more clearly on the ICB's responsibilities:

- *Finance strategy and planning* – a better resourced team that will allow the ICB to be proactive, alongside the Strategic Commissioning team in designing and enabling a system financial strategy that is equitable and sustainable.
- *Finance operations* – delivering consistent ways of working, with pro-active finance business partners across the ICB, adapted to support each area of the organisation (e.g. including strong contract finance capability and capacity where necessary). This will enable delivery teams to better manage and control their budgets.
- *Financial accounting* – the existing team will remain substantially the same but will drive new ways of working such as "no-PO no-pay" and also any changes in practice associated with the new version of the enterprise reporting and planning (ERP) system in 2025.
- *Contracting* – the contracting team will be more integrated within the finance function, supporting the implementation of provider contract envelopes and working alongside finance and delivery colleagues as part of the integrated provider oversight function in the Delivery Directorate.

Working with our Place partners

13. For these changes to be both affordable and effective in their implementation, we have had to consider other aspects of our ways of working, including the way we resource our partnership working at Place. We recognise the central importance of Place partnerships in the effective delivery of NHS services and other services provided by partners across the Integrated Care System.

14. To date, our support for Place based working has been provided through three separate Place based structures (Buckinghamshire, Oxfordshire, Berkshire West). This model has clearly progressed this way of working. It has established defined work and delivery programmes and supports our vision for the development of partnership structures and accountabilities.

15. We remain absolutely committed to supporting the development and strengthening of Place partnerships including our work with statutory and Voluntary, Community, Social Enterprise (VCSE) organisations. Our revised operating model retains dedicated resource focussed on each of our three Places. However, we also need to balance this with the need to effectively deliver our core, system level responsibilities.

16. As we explore this new model, we are very keen to work with partners within our places to discuss options for further strengthening Place based leadership within our system including through greater partner representation in key forums.

    How is this reflected in the operating model?

    - *Place focussed resource* - In the revised ICB structures, we retain resources that have a dedicated focus on each of our three Places through the Associate Director and Deputy Director roles. These teams will support the co-ordination of Place based programmes and priorities, the effective running of Place based governance and engagement structures.
    - *Place leadership* – We want our teams to be better connected both with each other and with other ICB teams. To achieve this, we will have one Director level post that oversees and coordinates both the dedicated local leadership posts and the joint commissioning structures. The role will be responsible for continuing the effective development of Place based governance models, play an active role in decision making required to support Place partnerships and ensure the partnerships are supported by the enabling and statutory functions discharged by the ICB.
    - *Urgent and Emergency Care teams* – In the operating model our urgent emergency care (UEC) teams will be consolidated at system level. They will work in a matrix model to deliver and support local improvement programmes and oversee Place based operational delivery. They will also provide a more system-wide approach to UEC transformation and change.
    - *Place based partnerships* – will continue to be supported from teams within the ICB with Place facing roles and / or capacity such as within primary care, health inequalities, long term conditions and safeguarding. The ICB will also ensure access to the necessary corporate support functions in terms of finance, business intelligence. Through this approach we aim to achieve a better sharing of skills, capabilities and experience.
    - *Joint commissioning* (including mental health and learning disabilities services, special educational needs and disabilities (SEND) provision, children's services and the Better Care Fund) – recognising the differences in the existing joint commissioning structures, the joint commissioning teams will report through the Director of Place and Communities who will work closely with the dedicated place facing roles to ensure effective joint commissioning. Elements of the Berkshire West team are integrated into the system Mental Health /Learning Disability team to support resilience as no formal joint commissioning structures are in place outside of the Better Care Fund (BCF).

- The ICB will continue to support the development of *oversight models* for partnerships (incorporating quality, performance and resource management) as they develop alongside our oversight role and responsibilities with NHS partners.

Opportunity to provide feedback

17. Through these changes we expect to be able to support each of our three Places to thrive and strengthen. However, we acknowledge these new approaches will take time to refine and to establish new ways of working. We want to continue to explore with our partners where there might be opportunities to improve how we deliver effectively together.
18. We continue to invite feedback from our partners on the revised model and would welcome feedback from you or colleagues. Please respond through our engagement email address (bobicb.opmodel@nhs.net). Alternatively, ICB colleagues would be very happy to attend or arrange a meeting to discuss these proposals in more detail.

APPENDIX 1: Changes in ICB structure to support the revised operating model

Current ICB structure:

- Service leadership at system level is split across Executive Director portfolios e.g. Elective care (Chief Delivery Officer), Primary Care (Chief Medical Officer), Mental Health (Chief Nursing Officer)
- The ICB strategy capability is limited by capacity to targeted interventions
- Operational planning is led through the Delivery directorate
- Place Directors are supported by Assistant Director / Deputy with direct line management of joint commissioning structures and local UEC team.
- Place teams are supported by a matrix model from system-based team for primary care, health inequalities etc

Proposed ICB structure (April 2024)

- Removal of vacancies and streamlining all structures to reduce overall cost base
- Place model retained with some additional partner funding identified to support. structures and a proposal to discuss whether Place based partnerships could host Place based resource in the future.
- Creation of a strategic commissioning function in Chief Delivery Officer portfolio focused on supporting partnership models (Place based partnership and Provider Collaboratives) and strengthening the join-up between performance, planning and contracting
- Support the Acute Provider Collaborative with a possible transfer of staff to a host organisation.
- Creation of system transformation team within strategy.
- The consolidation of governance, communication and engagement and Digital, Data and Technology (DDAT) team into a new strategy, transformation and digital directorate.
- System service leadership, split across executive portfolios, remain largely unchanged

Revised operating model (July 2024)

- Continue with the removal of vacancies and streamlining all structures to reduce overall cost base.
- The strategic commissioning function is transitioned into the strategy directorate and will include a system planning function, partnered with finance and strong matrix working with the delivery teams of the ICB.
- A single VSM Director of Communities and Partnerships is created to provide leadership across all three Place teams.
- Place Assistant Director/ Deputy roles remain – dedicated to specific Places.
- Joint commissioning functions will report through to the Director of Communities and Partnerships.
- The urgent and emergency care (UEC) team is centralised with a matrix model providing ICB delivery support to [system and] Place based UEC delivery and programmes.

- The contracting function is transferred to be integrated with finance.
- Mental health and learning disabilities programmes and performance oversight will move from the Chief Nursing Officer to the Chief Delivery Officer.
- All other performance oversight capabilities remain as part of the Delivery Directorate.
- Additional investment in All Age Continuing Healthcare (AAHC) and finance functions are proposed to strengthen the capacity and capability of these teams.
- The consolidation of governance, communication and engagement and Digital, Data and Technology (DDAT) team into a new strategy, transformation and digital directorate.
- Consideration is being given to the development of an integrated reporting function.

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Oxfordshire Joint Health Overview and Scrutiny Committee Substantial Variation or Substantial Development Assessment

A. Background Information
1. Name of responsible (lead) health organisation:
2. Brief description of the proposal (please include information about timelines and whether the proposed change is temporary or permanent):
3. Why is this change being proposed? What is the rationale behind it?
4. What are the main factors driving the change? Please indicate whether they are clinical factors, national policy initiatives, financial or staffing factors.
5. How does the change fit in with the wider strategic direction of healthcare in Oxfordshire and the Health and Wellbeing Board?
6. Description of population affected:
7. Date by which final decision is expected to be taken:
8. Confirmation that HOSC have been contacted regarding change - including. date and nature of contact made:

B. Assessment Criteria
1. **Legal Obligations:** Have the legal obligations set out under Section 242 of the consolidated NHS Act 2004 to 'involve and consult' been fully complied with?
Yes/No (please delete as appropriate)
Comments:
2. **Stakeholder Engagement**: Have initial responses from service users (or their advocates) and other stakeholders such as Healthwatch indicated whether the impact of the proposed change is substantial?
Yes/No (please delete as appropriate)
3. **Stakeholder Engagement:** Does the service to be changed receive financial or 'in kind' support from the local community?
Yes/No (please delete as appropriate)
4. **Stakeholder Engagement:** Is there any aspect of the proposal that is contested by the key stakeholders? If so what action has been taken to resolve this?
5. **Staff Engagement:** Have staff delivering the service been fully involved and consulted during the preparation of the proposals?
Yes/No (please delete as appropriate)
6. **Staff Engagement:** Do staff support the proposal?
Yes/No (please delete as appropriate)
7. **Patient Impact:** Does the proposed change of service has a differential impact that could widen health inequalities (geographical, social or otherwise)?
Yes/No (please delete as appropriate)

8. **Patient Impact:** How many people are likely to be affected?
9. **Patient Impact:** Will the proposed change affect patient access? If so how?
Yes/No (please delete as appropriate)
10. **Patient Impact**: How will the proposed change affect the quality and quantity of patient service?
11. **Patient Impact:** Does the proposal appear as one of a series of small incremental changes that when viewed cumulatively could be regarded as substantial?
12. **Patient Impact:** How will the change improve the health and wellbeing of the population affected?
13. **Wider Impact:** Will the proposed changes affect: a) services elsewhere in the NHS b) services provided by the local authorities, c) services provided by the voluntary sector?
14. **Standards**: How does the proposed change relate to the National Service Framework Standards and commitments under the NHS Constitution?
15. **Risk:** What could the possible negative impacts of the change be? What mitigations are in place to reduce any potential negative impacts of the proposed change?

C. Outcome/Decision
1. Is this considered to be a significant change by the commissioner/provider?
Yes/No (please delete as appropriate)
2. Is this considered to be a significant change by HOSC?
Yes/No (please delete as appropriate)